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1970 student health coalition

PROJECT COMMUNITY OUTREACH II

SUMMARY REPORT

VANDERBILT UNIVERSITY
VANDERBILT SCHOOL OF MEDICINE
MEHARRY SCHOOL OF MEDICINE

NASHVILLE, TENNESSEE

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SUMMARY REPORT

STUDENT HEALTH COALITION - PROJECT COMMUNITY OUTREACH II

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FOREWORD

The following is a summary report of the Student Health Coalition summer project for the year 1970. The date of composition for this, the main body of the report, is October 30, 1970. As of this date, computerized data concerning the patients examined and screened in the rural project this summer has not been completed. A supplemental report, including this important data, will be released during the month of December 1970.

PROJECT SUMMARY

Introduction and Background of the Project

In October of 1968, the Josiah Macy Foundation sponsored a student conference in New York attended by representatives from fifteen medical schools in the United States to discuss whether or not it was felt the radical student movement was or would be involved in the direction of medical schools. During this conference the Macy Foundation offered to consider the financing of projects which the conference participants might submit. The representatives from Vanderbilt suggested a joint Vanderbilt-Meharry urban-rural summer project designed to familiarize the students with medical problems in each area and to facilitate planning for future student efforts.

The student group was named the Student Health Coalition and obtained a Macy grant of $9,600 with Dr. Amos Christie, of Vanderbilt, and Dr. Leslie Falk, of Meharry, as principal investigators. The six Meharry students participated in the activities of Meharry's Neighborhood Health Center despite being plagued by a number of administrative problems.

The rural component of the project initially involved the examination of Head Start children in Williamson County, Tennessee, with five medical students and two volunteer one-year postgraduate nurses. All participated on an equal basis, nurses and first-year medical students doing physical examinations.

In late July, the group moved on to Clairfield, Tennessee, at the invitation of the local group, to assist in a health fair. Because of political pressures placed on the OEO Director in Clairfield, the presence of additional outsiders was deemed unwise and the group moved on to another health fair in Frakes, Kentucky. This fair was sponsored by the Council of Southern Mountains and the Presbyterian Church. Diagnostic screening was provided by visiting teams of medical people and by a multiphasic screening van from the Kentucky State Public Health Department. The next two weeks were spent in Jellico, Tennessee, and Evarts, Harlan County, Kentucky.

During the final week of the summer, the group returned to White Oak, Tennessee, where a health council of local citizens was formed. This health council sponsored the students in putting on a three-day health fair at the White Oak school. This was the group's first attempt at a health fair of their own, in the course of which a great deal was learned about logistics and the need for community involvement and follow-up.

By this time, the group had become aware of the Model Valley area, encompassing the geographic area of the Clear Fork Valley, and the efforts of residents of the valley to organize themselves. Two community groups, one in Frakes and another in Clairfield, had built and were running medical clinics staffed by a nurse and visited weekly by a physician.

Seeing in the concept of a community-run clinic--staffed by specially trained nurses and visited weekly by a physician--a possible solution to many of the rural health problems the group had encountered, the Student Health Coalition included in its planning for the following summer such ingredients as community organization, adequate follow-up, and the training of nurses in diagnosis and treatment of common diseases. It was felt that not only could community action take place but that students and faculty could be sensitized to a number of health care and community problems which might lead to actual changes in the production of health manpower.

Dr. James Craig, Medical Director of TVA, was contacted late in the fall. He was able to provide a multi-phasic screening mobile unit and a second unit with examination and minor treatment facilities. With the assurance of these facilities and the pledge of cooperation from the State Public Health Department, students proceeded to write grant proposals for another project.

Initial contacts were made with communities either through existing health councils, as in Clairfield and White Oak, with the OEO, as in Murfreesboro and Smithville, or through the PTA, as in Habersham and Briceville. In each case, we explained that week-long health fair could come at their invitation and that follow-up workers would be available. The idea of the community's sponsorship and responsibility was explained at great length.

As these plans and arrangements became more definite, physicians in the local areas were contacted either individually or through the County Medical Association in order to explain what we were doing, ask for suggestions, request their assistance, and inform them that a copy of the record on any of their patients that we saw would be sent promptly to them.

The recruitment of students did not follow a specific outline. We needed motivated, self-reliant, sensitive, and politically astute individuals who could be dropped into a basically unknown community and accomplish the tasks outlined above. The political awareness and sensitivity was extremely important in the case of the follow-up personnel, who would reside in a community for the entire summer. Because many undergraduates and nurses were enthusiastic about participating, we could afford

to be somewhat selective. Medical students, on the other hand, were extremely difficult to obtain. At this point we were extremely fortunate in committing Dr. Joe Moss, Chief Resident in Pediatrics at Vanderbilt Hospital, to work full time with us.

Parallel to these activities was the development of a project to be based in Nashville, working primarily with Welfare applicants and Foster Home children. The urban project was also unique in its bringing together medical students from both Meharry and Vanderbilt schools to tackle a common problem in Nashville. A more detailed account appears in the section on "Summary Reports."

Dr. Amos Christie served as principal investigator for the grant proposal submitted. By June, the project had been granted the following budget:

Tennessee Valley Authority	$ 5,000
Josiah Macy, Jr. Foundation	9,600
Field Foundation	15,000
New World Foundation	15,000
Appalachian Regional Commission	32,600
Regional Medical Program	10,000
Vanderbilt Medical School	1,800

* * *

During the summer, a great deal of time was invested in the introduction of faculty members and visitors to the project. This was felt to be necessary in order that as many people as possible see and understand the potential of allied health personnel, community organizations, and nurses outside their classic roles. It was also hoped that they might see the educational potential in such a program.

* * *

Some changes have already come about in both Vanderbilt Medical School, Vanderbilt Nursing School, and the student bodies of both, possibly due to the influence of the summer project.

In Vanderbilt Medical School, such new courses as Clerkship in Rural Health, Crises in Health Care, and Methods of Delivering Pediatric Medical Care in Rural Areas, have been instituted. The student response to such courses has been considerable thus far. (See Appendix for outline of courses)

Four pediatricians, rotating once a month and accompanied by medical, nursing, and undergraduate students, are being flown once a week to Clairfield and White Oak, Tennessee, to staff community clinics.

The Student Health Coalition is investigating possible administrative structural arrangements with which they might gain a commitment from the University for its continued interest and participation in the field. One of the most prominent structures being examined is that of an institute.

The changes in the Nursing School will be covered within their report.

Analysis of Data

A significant part of the man-hours comprising this summer project were used in keeping accurate records of the medical status of each individual seen. Besides the copies sent to local physicians, health departments, and clinics, one copy of each person's record has been retained, with the following objectives in mind:

1. From the individual "medical profile" we hope to derive a profile of the health status of the communities we served. Such a profile will consist mainly of numbers of diagnoses made, in appropriate age groupings, and of the final disposition in each case, whenver possible. Such a community health profile could be used to alert community groups, health departments, and those involved in planning a summer project for next year to the most numerous and/or critical problems in the community.

2. The analysis of the data collected will also allow quantitation of the medical services provided to these communities by this student project, and hopefully will help to demonstrate the usefulness of this type of medical tool and its applicability to these circumstances.

3. Data analysis will furthermore be an important part of our process of self-evaluation. It will be particularly important to assess the effectivenss of one approach to follow-up. Final plans for future projects cannot be made until this aspect of self-evaluation is complete.

At the time of the compilation of the major part of this report, the statistical analysis of medical records will not be complete. It is hoped that this will be completed early in November. The primary analysis will then be reviewed with the above objectives in mind and, along with an evaluation of this aspect

of the project, the results will be published as a separate appendix to this report. This will be made available to the appropriate groups and others upon request.

SUMMARY REPORTS

The Mobile Unit

Pat Maxwell and Kathleen Brewer

Eleven medical students, twelve nurses, and twenty-four paramedical personnel traveled with and operated the mobile unit structures this summer. Additional and invaluable personnel were Jim Pulliam and Larry Napier, technicians employed by the Tennessee Valley Authority who aided in the workings of the units as well as the supply of materials and coordination of the mailings of blood samples and PAP smears to Chattanooga for readings.

At the June orientation meeting, the mobile unit staff formulated the following as its goals for the summer:

1. Working with the local health group and in conjunction with follow-up workers to provide a week-long health operation involving:

   a. physical screening of all persons (laboratory and physical analysis)

   b. health educational measures (informational films, etc.)

   c. preventive measures as topical flouride application and immunizations.

   d. mental developmental screening (in certain areas).

   e. arts and crafts emphasizing child involvement with expression of creativity.

2. In conjunction with follow-up workers, trying to procure additional evaluation and treatment for those so needing through local doctors and existing programs.

3. In doing the above, working toward a means of establishing new channels of communications and service in health fields.

4. Listening to thoughts of local people to determine their priorities and assist them where possible in working toward solutions.

5. Involving local persons in the health operation in an effort to stimulate interest (especially among the young) and possibly to influence vocational choice.

6. By working and living with these people, learning from them some aspects of life unteachable in conventional educational manners.

7. Broadening our horizons as to the current complexities, problems, and failures involved in the distribution and delivery of health care.

8. Observing and evaluating the effort in teaching physical diagnosis in a short amount of time to health persons of limited training (first-year medical students, nurses and nursing students) and their ability to handle "well-patient" physical examinations.

9. Obtaining the involvement of numbers of the faculty of Vanderbilt Medical School in an effort to stimulate their interest in areas of health care delivery of the community.

10. Through our experiences of this summer, considering the adequacy and direction of our current medical education and how it, if so needed, might be implemented or altered.

11. Leaving with each local group our knowledge of the evolution of nurse-run clinics or other facilities and approaches to medical problems which have been developed in communities similar to their own.

The mobile unit operation justified itself only in the belief that something lasting can come of its sporadic efforts in the mountains--both in the attempts to further the expansion of medical care and in the expansion of the medical education of the students involved in the project.

The mobile medical units traveled to eight different communities, six of them in mountainous eastern Tennessee, to provide "health fairs." (See map) In each community, a health fair of six days, running Monday through Saturday, was provided. Hours varied in each community; seldom did the group finish work before 7:30 in the evening, and once in Smithville, Tennessee, there were patients remaining to be seen at 12:30 A.M. Days would begin at approximately 8:30 A.M., with a brief meeting to assign jobs for the day. Often, in the evening, another brief meeting was held to evaluate the day's functioning. As

the unit screening process became more efficient with the passage of time, such evening meetings were gradually discarded.

Health fairs were set up usually in a community meeting house or school building. Patients were funneled through a maze of record-keeping, following the ensuing pattern:

1. Registration and history
2. Height, weight, eye check
3. Receive urine cup and numbered tapes for blood samples
4. Physical examination
5. Lab work: EKG, x-ray, audiogram, spirometer, etc. ON UNIT
6. Blood work
7. Immunizations

Children had a blood analysis and urinalysis performed; all patients over 16 years of age had an x-ray made; women over 35 and all men received elctrocardiograms. A patient could get through the screening process, on an average day, in less than two hours.

Local physicians and medical professors from Vanderbilt University, whose interest and assistance had been solicited before the project's start, were on hand during the week as supervisors and consults. At one point, during the first week of the project's running, there was a lack of adequate medical supervision; this was corrected in ensuing weeks.

Volunteer workers from the community were solicited for the fair in advance by the follow-up workers residing in each community. Volunteers performed such ancillary functions as aiding in registering, the taking of histories, measuring height and weight, administering eye chart tests, performing dipstick urinalyses, and serving as guides and messengers during the fair. Training to volunteers was administered by the mobile unit teams on the afternoon prior to the health fair, at which time there was usually a community meeting for all who wanted to participate. The health fairs generally generated a great amount of community excitement and interest--more so, it was discovered, when a grass-roots organization (rather than, say, the OEO), sponsored the health fair.

Blood samples, VDRL samples, PAP smears, x-rays, and electrocardiograms leads were mailed daily to TVA headquarters in Chattanooga, Tennessee, where they were read by experts and the results forwarded immediately to the mobile unit. Such readings usually took four to five days. Upnn their arrival, the mobile unit staff would begin holding evening meetings after

the day's work, evaluating cases according to both the data returned and the notations made during the physical; cases in need of follow-up were set aside for the local follow-up staff to take over. Actual follow-up work, except for emergency cases, usually began a week after the fair began in a community.

Efforts were made to allow the mobile unit personnel to live with community families during the health fair. Often the unit personnel participated in such hospitality; those who were too exhausted or who did not elect to stay with families slept on the mobile unit. Most of the personnel who did stay with families bemoaned the lack of time for late-night conversations yet enjoyed even their limited contact with mountain and rural life-styles.

Satellite Health Fairs - The mobile unit experimented this summer by conducting two "satellite" health fairs during the week of August 3-8. The "official" health fair was being held in Habersham, Tennessee, a small community from which large crowds were not expected. On two different days of the week, 7 unit staffers gathered up blood, VDRL, PAP and other examining equipment, and went to two tiny communities in the same general area as Habersham for a one-day health fair. On Kentucky Hill, a ghetto area in Jellico, Tennessee, the group saw 70 adults and children; all work but x-rays were performed on these residents. The group put on the health fair in a one-room cinderblock building with no plumbing or air-conditioning--such adjustments were made as sending patients to the nearby privy for urine samples.

The second satellite fair was held in Elk Valley, at a school. Over 150 residents were seen on that day; the Health Department sent over a mobile x-ray unit for the afternoon.

Follow-up workers in the area contacted local residents of each community prior to the health fair to secure community and volunteer support. Actual follow-up work is being conducted by two nursing nuns residing in the area.

The mobile unit staff felt that comparable medical care was delivered at each satellite fair. It is likely that such small fairs can be used in the future to fill the immediate medical needs of tiny communities.

Various problems and differences in priorities arose during the summer among the mobile unit staff as the drive for total efficiency, coupled with overwhelming crowds and anxious follow-up staffers, increased with the hours worked. Objections concerning the functioning of the mobile unit were usually concerning 1) efficiency, and 2) diminishing the inhuman strain put

on each mobile unit staffer because of the constant need for efficiency. Thus, the suggestions occasionally ran counter to each other as the group struggled with the question: which is more important in this rural situation, quality care or quantity care? Suggestions concerning both quality and quantity care, polled from summaries provided by each mobile unit staffer, follow.

Concerning the Functioning of the Mobile Unit

Dull jobs should be rotated to avoid tedium; however, a set group should work on each trailer in order to insure maximum efficiency.

More ancillary personnel should be included on the unit to help with paper work and with emergency situations, bottlenecks; this would free more time of the medical students for examinations, etc.

Adults should possibly be pre-screened for physical problems so that not so many time-consuming examinations would have to be conducted.

Working hours should be shorter; one medical student noted that, when he was rushed, he felt that he often missed subtle clues to pathology. He noted, he said, more pathology on slow days than on rushed ones.

Histories should be done with better quality and more consistency. Most likely, histories should be conducted in private and not be local residents.

Definite steps should be taken to insure that medical supervision is present at all times during the health fair.

Only third year medical students should examine adults, to insure more reliable and experienced work done.

Mobile unit personnel should have an opportunity to work on follow-up, in order to see and experience the less clinical aspects of medical care in rural areas. Also, such work would ease the mental tensions that build up around repeated jobs such as those on the mobile unit.

A decision-making body or heirarchy in the mobile unit should be set up so that group decisions can be made on an organized basis and so that meetings for discussion can be limited.

Time off from the hectic unit schedule should be allowed--perhaps a free week in the middle of the summer or a couple of long weekends would suffice for solitude and time to reflect on the summer's activities.

Some means should be found by which lab results can be returned to the mobile unit faster than they were this summer. In this way, follow-up can be started immediately.

The pace of the health fairs should be slowed, if possible, to allow more interaction between the medical teams and the local residents.

All these evaluations, be it noted, presuppose that the future operation of the mobile unit would be on the same general pattern of "health fairs" as attempted this summer. Many of the mobile unit personnel, however, offered suggestions for modifying the "health fair" concept in coming years.

Follow-Up

Kathleen Brewer

Follow-up work, the second prong of the summer project, initially involved nine students as staff. None of the students were trained medically. All but one, who was studying environmental engineering, were Arts and Science students at Vanderbilt; three of these were graduating as of June. Many of the follow-up workers were chosen due to a history of community work and organizing while at Vanderbilt, and most of the students had worked together before.

During the two-week orientation, follow-up workers devoted most of their time to familiarizing themselves with the details of public assistance laws and to developing a relationship with the law students in the project. The goals of the follow-up staff were the following:

1. To prepare for the arrival of the mobile unit by seeing that the community has all plans made.

2. To carry out follow-up work on individuals with medical problems: a) by making the necessary preliminary connections with area medical resources; b) by getting people to doctors; c) by arranging financial assistance when possible and when desired.

3. To make plans for long-range follow-up work to be conducted by the community (i.e. to have the community make plans): a) community responsibility for individuals; b) continued Vanderbilt involvement through University participation or through student organizations.

4. To come to know the community on as many levels as possible and to establish some basis of friendship and trust: a) identify leaders; b) know structure and procedures of welfare departments, health department, local doctors, local medical association, comprehensive health plan, community government, county government, citizen participation on public health board, etc.

5. To learn the priorities and problems of the community, as it sees them.

6. To influence Vanderbilt to use its expertise in the

resolution of community and health problems.

7. To raise the general health and community development consciousness of the communities.

Of notable importance is the dual role envisioned by the follow-up staff: one, as preparer for the mobile unit; two, as an advocate and facilitator of a community health group in each area.

For all the follow-up teams save one, the second priority assumed the greater amount of time and conscious thought as the summer developed. Working in teams of two (usually a male and a female), follow-up workers resided in their assigned communities during the entire summer, housed by local residents. All amenities to local dress and custom were made so that workers could "fit in" to the community and gain some reliable sense of problems and priorities in the area. Most follow-up workers found this effort to be both personally rewarding and highly important to the work of the project, in terms of advising as to what help from the University and what encouragement at meetings the group could offer. The one area where such an endeavor met with little success was in Smithville, Tennessee. A full report is included.

Follow-up teams resided in White Oak, Sneedville, Deer Lodge, Briceville and Smithville, Tennessee. In four of these areas (Smithville is excepted here), organized health groups remain at the end of the summer's work. White Oak, Tennessee, already had a well-organized group before the staff's entrance into the mountains; the remaining three communities developed their groups with the help of follow-up workers and are at various stages of organization and planning (see appendices for detailed analyses of each community.) Though the groups are young and still seem to be in need of encouragement and some guidance, the follow-up teams are convinced that such organizations complement the nomadic pattern of the rest of the project in providing realistic possibilities for the actual improvement, on a long-term basis, of health problems in the area.

The final task--and indeed the most overwhelming in terms of time--attempted by the follow-up workers was the actual follow-up on cases screened by the mobile unit during its stay in each community. Data returned at the end of each "health fair" was appraised by the medical group and returned to the follow-up workers. From this point, the teams set about arranging medical treatment for those in need of it. Often, this was a matter of complicated referrals from scarce physicians or arrangements for government financial aid. For many problems, such as dental caries or eyesight deficiencies, there simply was no available treatment. In some areas, such as the White Oak-Clairfield area, there was an operative community clinic, with a physician once

a week; this clinic, while extremely helpful, could not handle all the referrals because it dealt chiefly within its county lines. Two communities, White Oak and Habersham, were organized enough to hire a local resident in each place as "medical secretary" for their group, using funds from a Regional Medical Program grant. These people, members of groups which plan to open a clinic in the future, worked directly with the follow-up teams and were trained to continue follow-up after the project's close. The Sneedville community organized and conducted a repeat-blood pressure clinic to aid in its own follow-up.

Legal students working with the project helped often on follow-up, performing some of the visitations and helping tackle the volumes of paper work required for record-keeping. In cases requiring government program assistance, the law students were invaluable as semi-professional liaisons with physicians and with members of the local governments.

The follow-up staff noted a number of decisions and tasks during the actual medical follow-up that they were incompetent to handle, such as deciding priorities of cases, performing repeat blood test and blood pressures, and interpreting notations made on the charts by the medical teams. A "floating" nurse and medical student, which visited most of the teams as the follow-up work began in each area, helped a great deal; however, more consistent help of this nature would have been desirable.

In all areas visited by the mobile unit, follow-up work continues. Some students employed by the project have been rehired for a few months into the fall to keep a close check on follow-up progress; others are donating their time to visit the areas on weekends and work with local health groups as best they can.

In a meeting of the follow-up staff on August 28, at the official close of the summer project, the following recommendations concerning the follow-up of future projects were made:

1. Cars should be arranged for all follow-up workers next year to insure mobility and thus a more efficient use of time.

2. A nurse or a medical student is necessary to the success of each follow-up team. Such a person should reside in the community for the entire summer, familiarizing himself with the available health facilities and with the general community needs. It is hoped that, in this way, the actual medical follow-up of the project can be more comprehensive and more sensitively adapted to individuals which are affected.

3. The need for medical excellence in follow-up, added to the inherent educational value of living in communities, affects the recommendations of the follow-up group concerning the future organization of health fairs. Follow-up workers noted a consistently low quality in the work-ups done on many patients--a low quality necessitated by the vast number of patients being seen each day by the mobile unit staff. Information as to income, insurance, address, family status--important to the follow-up worker--was often omitted. It was felt that if fewer patients were seen each day that the medical students would have time to give the patient more comprehensive care.

   One means to accomplish this would be having the mobile unit remain in a community for a two-week fair. It is possible that the entire mobile unit staff could remain in the area for as long as a full month; in this way each medical student could personally follow up his own patients as well as benefit from dwelling in a community.

4. Included in each summer's plan should be the hiring of follow-up personnel to continue not only medical follow-up but also close communication with the local health group, months into the autumn. Many nacent health groups are now at vital points of organization; that they be abandoned by our project would be unfair and perhaps diastrous for them.

The following two reports are personal summaries by follow-up workers in two different areas. The first is of Smithville-Murfreesboro, the one area where no organization was begun. Certain circumstances which were experienced there warrant its special attention. The second is from Briceville, which more typically exemplifies the problems and achievements of community work in the project where development of a Health Council and its leaders and activities were more successful.

Smithville Report
(compiled from individual goals of
Austin, Bell, Ecker, Graf, Schmidt,
and Baile)

Goals

1. To become sensitive to community needs and priorities. To develop or seek out a viable community group so that a) both insiders and outsiders have an instrument with which to measure the needs and feelings of the local indigent citizens, and b) any projects related to their major concerns that we assist with will be taken over and continued when we leave.

2. To insure that all people seen by the Mobile Unit who need additional health care are visited by one of our group, that their records are discussed with the appropriate physician (investigate local resources).

3. Record progress and group decisions, actions, failures, suggestions for future, etc.

Special Interests

1. Determine the need for a prenatal clinic in DeKalb County, and set up such a clinic if feasible.

2. Collect necessary Rhogam research data from each of the three counties (Rutherford, DeKalb, Cannon) and make appropriate recommendations.

3. Follow up on the children who score low on their Denver Developmental Screening tests.

4. Provide assistance as possible in well-baby clinics. (In what ways might a mother be taught some fundamentals in home health care while at the clinic?)

5. Through home visits and work with community people, assess interest in setting up a home nursing course. This must be a community organized project to be effective.

Perhaps our biggest problem, in our own way, was time. Running a close second was the fact that in both Smithville and Murfreesboro all of us were new and necessarily still experimenting with the possibilities presented to us both in the mobile unit itself and in a community where a government agency was responsible for our presence.

Ten of us--six nursing students, two psychology students working in mental health, and two community workers--moved in to a farm house a week before the fair was to be in Smithville. We found that the OEO had done little in the way of preparation for us due, it seemed, to 1) Rubella Sunday which was the day before the unit arrived and which was taking a lot of time and people to operate, and 2) to a certain amount of confusion in the OEO office as to just what we were all about. We felt that a part of this confusion might have been avoided if only one or two people had conferred with the OEO people rather than all ten of us at different times. Communication was difficult to keep track of, and resulting misunderstandings caused them to do nothing rather than what needed to be done.

We, therefore, spent the first week almost entirely on recruiting volunteers and publicizing the Fair. Because of time limits, we were forced to call on already established groups for assistance with the result that the Fair was put on by the middle-class citizens of DeKalb County. There was very little participation by the indigent, and we had very little appreciation at that time for the real situation as far as poverty population was concerned. We decided to wait and see what kinds of people and problems showed upat the Fair in order to have a tool to guage how we could best utilize the rest of the summer.

We found generally that primary medical health care delivery in Rutherford County as well as in DeKalb was not a severe problem. Although its quality could be questioned, the quantity was remarkable, local transportation was usually covered by Neighborhood Service Center aides when called upon, Medicaid/Medicare cards were accepted by enough doctors to take care of most crucial medical problems, the Public Health Department followed easily and without complaint the anemias, some acuities, and some dental problems.

Toward the end of the last week in June, the Smithville group sat down to discuss what we had found and where to go from there. All of us felt that although there was some need for perhaps a pre-natal clinic or even some sort of council to be put together to speak for the indigent population, personnel, resources, and community support were lacking at that point.

We decided that we could best spend the rest of the summer with a very different approach than we had originally intended. If the Fair was to have been a "feeler" to find out what sorts of medical problems there were in the area, then what we found was that there was no serious problem in either Rutherford of DeKalb. If the Fair was to have been a catalyst in forming some sort of Health Council by giving them their first major project to work on, then we arrived far too late, as there was no viable local representative group to work with. We were at a definite disadvantage for having been invited in by a government agency.

Individual choices were made which led to three of the nurses and one of the community workers moving on to the mobile unit for the rest of the summer; two psychology students moving to Briceville; one nurse moving to White Oak; and two nurses and one community worker remaining in the house in Smithville to do the follow-up work in Rutherford and DeKalb.

The follow-up work for Rutherford and DeKalb Counties consisted of contacting some five hundred people, total. There were a great number of problems encountered here, most of which were remedied or at least noted for future reference by the time serious follow-up began in the communities visited later. Recommendations and suggestions are listed separately.

Although the home visits were most often very rewarding, the work as a whole was discouraging for the three of us. We knew we would be leaving the community with no long-range programs and most contacts we had with local people were in the Welfare Office or the Public Health Department. It took us far too long to finish up, mostly because we were experimenting in methods as we went along and had to make time for our mistakes. We did not know the geography well enough and so spent on the average 30 to 45 minutes per home visit just trying to find the families, most often through the Post Office or the local general stores. We were also extremely limited with only one car between us. The Stones River OEO project, which included Rutherford, DeKalb, and Cannon Counties, was in the process of splitting up and reorganizing on other geographical boundaries and was, therefore, plagued some by power plays and some new inefficiencies. As we depended upon them quite a bit for resources, this realignment business also helped to slow us up.

Generally, there seems to be no serious problems in these two counties as far as medical health care delivery is concerned. We saw far too many carious teeth, and a surprising number of bad ears, particularly in children. But we all agree that perhaps their greatest problem as a community is that nearly everything is still being done <u>for</u> the people on the part of government

agencies, and rarely if ever by them or with them. An unfortunate and discouraging attitude of complacency pervades these two counties, and involvement in community projects seems to stem more from a desire to "look good" than a genuine concern. One would be hard pressed to find a simple cure for these ills.

Cannon County - A brief note should be made of our encounter with Cannon County. This county sits between Rutherford and DeKalb and had been very informally approached through Head Start and some OEO staff members about Fairs in Rutherford and DeKalb. They had arranged to bus some children and their families to Murfreesboro and some to Smithville for their physicals. We considered for a short time setting up a satellite clinic in Woodbury, mostly because of reports from reliable sources (local people) that good medical care was extremely difficult to find there, most especially for the indigent. Non-paying patients were refused by the hospital, even an occasional pregnant woman in labor. Although two or three local women were prepared to work out the arrangements on short notice, the local doctors set up remarkable roadblocks, including social pressure and threats, and we never went. We considered some community organization work there while working on follow-up in Rutherford and DeKalb, but finally decided that the chances for any success along these lines, given the small amount of time we had, were slim enough to warrant our moving east to help out there as soon as possible.

Perhaps some further investigation into the situation in Cannon would be fruitful. The doctors seem to control the community and are obviously opposed to any outside projects which might take away their "business." They even opposed for a long time an immunization program at the Public Health Department and have thus far prevented a family planning program to get off the ground. The Public Health nurse will not move without their permission. But no efforts should begin there without a good feeling for and support from some segment of the community, probably the indigent, since they have nothing to lose.

Briceville Report

(Karen Blaydes)

The Community

Briceville is a town of approximately 2000, according to estimates of community residents. It is a former mining town, with houses clustered closely together, extending from the small valley area around Coal Creek, up onto the hills immediately surrounding the valley. Our general area of concern consisted of a radius of about 15 miles, including the communities of Caryville and Clinton (the county seat) on the east, and Laural Grove, Frost Bottom, Oliver Springs, Dutch Valley, Rosedale and Devonia on the west. The area included roughly the nothern half of Anderson County. Briceville, as the general area shall be called, seems to be more affluent than other communities visited by the mobile units this summer. Although the main source of income is gone (the mining industry), a fairly substantial portion of the community (perhaps 40%) is employed in Clinton, Oak Ridge and even Knoxville, usually in capacities such as machinist or factory worker, etc. A few small deep mines are still in operation, and some strip mining provides jobs for a few men. About 50% of the community is said to be on welfare, and although we obtained no statistics, this seems to be a reasonable figure, as could be ascertained through observation. A very definite and sometimes acrimonious distinction is made between the people who work and support themselves in the community, and those who are on welfare. The resentment seems to be aimed primarily at the men--former coal miners, who are unable or sometimes have not tried to find new sources of employment. Those men who do hold jobs in Oak Ridge, frequently had to leave the mountain area entirely in order to obtain the training necessary for such employment. For many in the community, this is an impossibility, either physically, psychologically or emotionally, and it could well be that the amount of alcoholism is proportionate to inability to improve upon conditions.

Although there was more income available in this area than in some and although Anderson County has many more resources and facilities for health care--all dimensions of health care--than other East Tennessee counties, these facilities and services were only infrequently available to the Briceville community. County wide, Briceville is thought of as something of an outlaw town, full of rough people whose recourse is to violence rather than to judicial mediation of disputes. Thus, Briceville is generally unable to make use of county facilities and has been ignored in petition to the county. For example, since 1964,

citizens of Briceville have worked through various channels to obtain flood control on Coal Creek around Briceville. During that period, flood control work was done around Lake City and Oliver Springs, but Briceville carried neither political nor economic power to a degree sufficient to influence action in its behalf, and was definitely not the recipient of any county generosity. Strip mining ravages the mountains, adds pollutants to the water, and washes down hugh strips of mountainside, and no attempt at reclamation seems to be made. The creek continues to flood, doing much property damage and frequently taking lives. The medical care that is available is usually available only to those who can pay, and most medical facilities in the area no longer accept Medicaid patients, having fulfilled personally set quotas for the year. Finally, the death of the community's one previous source of identity and income, coal mining, leaves many people jobless.

Throughout all of this, the church plays a very dominant part in the lives of most members of the community. All day singings with dinner on the ground provide weekly festivals which are greatly attended. There is a very passionate involvement in the church, and particularly in the services themselves, especially on the part of the men in the community. The future directedness of a religion which promises hope and happiness and no more hard work or suffering is certainly indicative of the very hard life most peoplein the community must face.

Leadership in the Community

When we arrived in Briceville, a Health Council was already in existence, formed from a PTA group and named the People's Health Council of Briceville. It was composed of a representative group of community leaders, those people who we discovered had been the leaders of every community effort in the past few years. The president of the health council is the community's single most dominant figure, Byrd Duncan. One of the few men to participate in any kind of community affairs, Mr. Duncan is a retired coal miner, age 70, who is president of nearly everything, and who can still out-hike anyone over the mountains. The unique strength and wisdom of this man seems to transcend the continual rivalries between groups, churches and neighboring towns. Those differences, though subtle and somewhat more sophisticated than those found in other communities this summer, hamper or impede the progress of nearly every activity in the community, except when Byrd Duncan is present. The health council was initially composed of 15-20 of the leading citizens of the community and did not seem to represent the welfare group at all and only minimally could be said to represent the lower economic level working families. This did not seem to be intentional in any way, but was the natural rule of community

participation in Briceville at the time. Mr. Duncan was firmly committed to changing that idea, as one of his primary concerns was to diffuse the work of the health council among all the members and he worked tirelessly for the inclusion of all the members of the community. The large bulk of work and direction continued to come from him, however. At the time of our arrival, the health council was well into making plans for the arrival of the mobile units, some five weeks hence, and planning food and housing for all the participants, as well as working on publicity. Much of this action was under the direction and guidance of Tom Finley, the County Health Educator, who was instrumental in bringing the mobile units to Briceville and in creating a health council out of the PTA group. The health council, then, was a conglomerate of interests and leaders, many of them long standing rivals and it somehow managed to remain always above and separate from the sources of rivalry and political issues. Health seems to be one of the few unifying factors in the community and every effort was made during the summer to maintain its neutrality as an issue.

Our reception into the community was a very warm one. The health council was not prepared to accommodate two follow-up people for the entire summer when we arrived at their health council meeting June 16. Tom Finley was to have relayed this request of ours and failed to make it clear. Nevertheless, we were immediately housed and fed and arrangements were made for continuing accommodation throughout the summer. The hospitality could not have been more gracious and seemed especially significant to me because the community did not know in advance that we were coming for the entire summer.

I thought of my role as an individual as supportive and receptive. It was my feeling at the beginning and at the end of the summer that my job should be to listen to the needs and desires of the community itself, to begin to understand the priorities, the values, the life style, the rhythm of the people and area, and not to tell them what they needed. I saw my role as one of resource person and facilitater of the wishes and desires of the community itself. The supportive role was one of encouraging ideas and directions suggested and enacted by the health council itself. Finally, I saw myself as a liaison between the community and the mobile unit, and between the mobile unit staff and the community. For the community I hoped to provide helpful information concerning the practical problems of conducting a health fair (i.e. how many people would need places to stay, what sort of volunteers would be needed, what equipment, etc.) and for the mobile unit staff I hoped to provide information about the community, its tensions, its feelings, its directions and interests. Finally, I saw my role as one of breaking the

ice, so to speak, in terms of having the community receive an outside group for any purpose, and one of actual follow-up worker in the sense that I had to learn where all the possible medical facilities were and who they would accept.

As a member of a twosome, I felt that my role was differentiated from that of John Davis by virtue of the delineation of sex roles in the community. I shared the confidence of many women in the community where he could not approach them, and vice versa with the men. This factor contributed significantly to the directions our initial explorations took, as we began to meet people and explore the many dimensions of the community and the area. The first part of the summer was in a sense the most difficult because we had to learn as much as we could, relying entirely upon the results of conversations with members of the community and finding the people whose names were mentioned as community leaders. At first it was a purely chance stabbing out, and as we became more familiar with names and groups and with the recent history of Briceville we were able to select and talk with some informational purpose in mind.

The health council itself seemed to make tremendous progress during the summer. The membership, though by no means regular in its attendance at meetings (people do not get things done by meetings in the mountains) continued to grow and expand to become a continually larger and more representative group. Part of this was due to our encouragement of various individuals and simple publicity devices, such as posters and general word of mouth announcements. But most of it was due to the growing excitement and enthusiasm of members of the health council themselves. The group was left without Tom Finley, immediately upon our arrival at the beginning of the summer, and as he had provided much of the direction and initiative, for a while very little happened and we were relied upon heavily to tell the health council what to do. Part of this was necessary because we were aware of the problems of the mobile unit in other communities and could look for ways to make the operation smoother in Briceville. It was our very strong feeling, however, that the health council be autonomous and we continued to try to diminish our role in its functions. After the Briceville health fair, with its great number of people (over 1150 examined) and the general success of the week, the health council, riding a crest of ecstatic enthusiasm, began to talk about building a clinic in Briceville. We were delighted at the initiation of such an idea, having feared that the momentum of the health council would die after the week of the health fair. We had talked to many individuals about possible next projects for the group, but nothing seemed exactly right. Without any direction or inclination from us, the clinic idea came up and was greeted with great enthusiasm. We saw our job in the remaining weeks as one of supporting the

continuation of such an idea and of helping set realistic goals and find avenues for accomplishing such goals. During the remaining weeks of the summer, members of the health council made a visit to the Clairfield clinic and talked to members of the White Oak health council, received a $500 grant from Community Action for follow-up transportation, received a gift from Dr. Spray, of Oak Ridge, of used office equipment (examining tables, a refrigerator, shelves, a medicine table, and a promise of sample drugs). They received a promise of a $250 gift to be given anonymously if the council was still going by December 1. Dr. Craig, of TVA, was very interested in the idea and helped the group look for possible resources and publicity. John and I began to contact sources in Oak Ridge and Clinton that we thought might be able to provide some financial resources. The health council began to look for land, took steps to incorporate itself as a non-profit organization, and sent a committee to approach mobile home dealers about the possibility of a gift or loan of a trailer. There is even a nurse in the community who might be interested in working in the clinic were it ever to be established.

As more and more developments occurred, I found myself carried away with the same enthusiasm the community was feeling. However, what may be an indicative sign crept in during the last two weeks of the summer, as the activities and directions were falling more and more on Byrd Duncan, and as the community members seemed more willing to give up (they came home after being turned down by the first trailer dealer they approached). As yet, my feelings are still mixed. I don't know how much momentum the council will have without us as supportive people on the side. Yet there is much promise. After the trailer incident, several women on the committee decided they would go out again, by themselves, saying that the men had not tried hard enough! And several community women who did not understand incorporation proceedings or bargaining for trailers turned to what they could do and began to raise money for the health council by bake sales. The possibility of crafts to raise money was discussed among them.

The general community reaction to the health fair was very enthusiastic. By grapevine, I learned that some people stayed away because they were afraid we were hippies "experimenting on people," but the turnout in Briceville and the enthusiasm afterwards speaks for itself. Every comment I heard was favorable and usually highly complimentary: "The best physical I ever had." "Even better than my Army physical." Among the medical results from the screening in Briceville, we found that approximately 25% of the people needed to be referred for additional tests and treatment to area medical facilities. This figure does not include the tremendous number of people with dental problems.

Medical Services in Anderson County

Medical services available can be divided into the following categories: 1) doctors, 2) hospitals, 3) additional health care facilities, 4) additional health programs. First, there are two general practitioners in Lake City, one in Norris, one in Oliver Springs, three in Clinton, and specialists in every field except ENT in Oak Ridge. There is a small hospital in Lake City owned and operated by the two doctors there and a large hospital in Oak Ridge. There is a public health doctor in Clinton with a staff of four R.N.'s, a mental health center in Oak Ridge, a rehabilitation center in Oak Ridge (Daniel Arthur), and extensive family planning programs, and several peripheral health services (i.e. the Lions Club provides glasses, etc.) Factors prohibitive of usage for indigent people in the county include lack of transportation, especially to Oak Ridge, inability to pay, tremendously long waits before being seen by a doctor, the refusal to accept Medicaid and the limited number of beds and facilities in some centers. In addition, some facilities in Knoxville are available to Anderson County residents, the cardiac and tumor clinics at the University of Tennessee Memorial Hospital, for example. There is also at least one nursing home in Lake City. While funds (the per capita income in the county was too high because of Oak Ridge, although it has been said that without Oak Ridge, Anderson County is as poor as any county in Tennessee), it does have an indigent medical and hospitalization fund administered by the County Judge, which is very limited. The reality of the medical situation, however, is that if one is indigent obtaining medical care is next to impossible. Even the county fund is so complicated that it takes at least a week and much leg work to get the funds authorized. And the inability to pay or the futile attempt to use Medicaid cards eliminates the vase majority of services available. Finally, though Public Health provided some clinics and some services, to enlist their aid in Anderson County was like pulling the golden sword from the stone.

In the event of emergencies, the Anderson County Rescue Squad could be counted on to provide immediate service, and emergency care was available in the emergency rooms at Lake City and Oak Ridge. Extended care following emergencies presented some problems, however.

Public Assistance Programs

As I mentioned earlier, the generally assumed figure for people on public assistance programs is 50%. John and I made very little use of these programs and made no contacts with these officials. In our area, law student Arnie Rosenfield

handled this. Knowledge of the programs seemed to be very widespread. Everyone knew about food stamps, black lung pension, all the aspects of welfare, etc. The reservations about participating in the programs seemed to come only from the families accustomed to working. Even in times of great need, they felt it to be very demeaning to be on welfare. This did not apply to the food stamp program, however.

General Questions

My impression of the dignitaries ushered around this summer was that they needed to see for themselves what we were doing, but I felt that no one on the staff we had had the time to do the ushering. There were a thousand demands upon the follow-up people that seemed immediately more imperative than trying to show someone around who knew nothing about the operation. I resented having my time taken doing this. However, I can see the importance and would thus suggest the inclusion of a public relations person whose sole responsibility would be this.

I certainly think the project has proven something at least to some people. I cannot adequately describe the things I have learned or compare them to anything in the past except to say that I feel that my sensitivity to problems and to subtle community feelings has grown immensely. I have no idea about the impact on the medical profession except to gather from the reaction, both favorable and unfavorable, that the project certainly did not go unnoticed. As for the people in the mountains, if we lessened the degree of fear or hostility to outsiders then perhaps we did a service. If we helped to create an atmosphere of determination to work for better health care, on the part of the people themselves, then we have certainly proven something. However, if we have raised expectations and have not been able to provide effective follow-up (and I have serious doubts here) or if we have raised expectations and hopes for improved medical care for this area, and it is not forthcoming, then perhaps we have violated a very serious trust, and must be held accountable. It seems to me that the responsibility incumbent upon all of us, by virtue of having participated in this project, is precisely to see that we have not raised expectations falsely or violated a trust placed in us by the people of these communities. In that sense, I don't think the project can end. To in any way give up or quit, or even lose touch with the areas we have visited because school is starting is to do precisely what every other "outside group" has done: to come and go, leaving the local area holding an empty bag of hopes. That may be excessively dramatic, but I think, nevertheless, true.

The one question posed in my mind, then, is how do we make permanent, improved health care which we have so tentatively begun this summer. I can predict no answers, only suggest my

feelings. (See the last section of this report).

The data we receive, both statistically and in the form of these reports, not just upon request, ought to be made available to everyone in the project. It should be used, as the nursing students have been using it, to continue to push for curriculum innovation in both the Nursing School and the Medical School, and also the Law School. It should be available to anyone wishing to push in his particular interest area (i.e. law students with strip mining, for example, or follow-up people looking for financial resources for clinics, etc.)

The actual function of each group, it seemed to me was: medical students and nurses, by virtue of the unanticipated numbers of people, an unavoidably overwhelming need to work lengthy hours on the actual screening, leaving little time or inclination to participate in other parts of the project; law students, experts in technicalities of governmental programs, approachers of bureaucrats (with excellent results), and investigation of various issues; follow-up, efficient exploration of the community but inefficient follow-up, for reasons explained below; secretarial workers and accountant, over-worked martyrs.

In terms of additional personnel in future projects, I think either numbers should be doubled or the goals of the project halved. It is my feeling that much of quality was lost in quantity. Perhaps that is inevitable.

Follow-Up Realities and Suggestions

I think the follow-up work was not and could not be adequately done due to the following factors: Slow return of the charts; unbelievable paper work that consumed much time; failure to include adequate addresses, financial information, parents' names and phone numbers; failure to specify clearly enough to non-medical people the pssible medical problems; not enough time in the last four towns to even begin to finish or recheck on people who said they would make appointments to see doctors.

That is not to attach blame to any individuals or particular groups at all. Some of the problems were the result of an inability to foresee everything, especially the large numbers of people. Part was due to lack of cooperation between groups. Part was due to a slowness in correcting mistakes (such as inclusion of additional information).

I would suggest that this summer's experience be a guide to improving the paper work.(Somehow we must get rid of the carbon paper)!

I think each follow-up team should include one nurse and one law student in addition to the two follow-up workers. Most of all, I think that each person on the follow-up team should

have to spend time working on the mobile unit, and that each mobile unit person should have to encounter the problems of following up. Problems such as the following:

Send out the letter to the person screened: he can't read. Go to see him: he can't be found. Try to make an appointment for him to see a doctor: he has no money, no Medicaid card, and is not eligible for any program. Try to find him a job or get him to a doctor: he has no transportation and is unskilled. Take him to a doctor: the doctor asks first "Who will pay?" etc., etc., etc.

Suggestions about a Concept for Health Care

For Briceville, and perhaps for other communities, I think the most feasible plan for improved health care is many faceted. Central to the idea, however, is one or a number of clinics, funded through any number of possible governmental or private sources, and staffed by a nurse, a medical secretary and a physician at least one day a week. This would provide some immediate medical care without the miles of travel now necessary and without the financial resources now needed. Such a clinic should be responsible to and responsive to the sponsoring group, namely the local health council. It should provide services for some minimal fee, waived when necessary, to assist in paying for drugs and supplies. Some sort of cooperative could be established that would allow an individual to make a certain number of marketable goods, crafts perhaps, if he is unable to pay. The profit from sale of the goods could go to the clinic as his form of payment. The clinic and the health council should be independent and autonmous, free of control or influence of any agencies, governmental or private, and responsible only to the community. I think funding for such a clinic is possible, through grants, funds from service clubs, etc. I would hesitate to name possible avenues for Briceville until the health council there is ready to actively and publically pursue them. The clinic should also include a referral system to the public assistance programs, the Public Health Department, to area specialists and clinics providing unique services.

All the above, I think, is possible. Essential to improved health care in Briceville and in rural areas similar, however, are other factors which may not be so possible. First, area medical facilities would have to be more flexible to receiving referrals from such a clinic, which theoretically would not be too frequent because many of the medical problems could be handled by the clinic. Area dentists would have to be more willing to do the same and, in fact, the clinic should include

a dentist at least one day a week as well. (Dentist and doctor both receiving a set fee for the day). Larger health issues would have to be explored and alleviated (perhaps on a county or legislative level): a purified water system, reclamation of strip mines, alleviation of flooding conditions. And finally, mental health would have to be considered: the possibility of getting jobs, getting training for jobs, getting day-care centers so that mothers can work, finding ways to return the lost identity of former coal miners. Concerning the latter needs, I am pessimistic.

Byrd Duncan says that if Briceville does not make the health issue work--if it cannot find ways to make this work--if it is blocked again, for whatever reason, then Briceville is dead. And he knows.

Legal Work

I. DESCRIPTION OF LAW STUDENTS PROGRAM

A. Background and General Comments

The idea of including law students in the student health project was based on the belief that the use of legal knowledge was important to the solution of health problems. The experience of medical students who had participated in rural health projects the previous year served to support this idea. They found an understanding of social welfare programs and their appurtenant rights was essential to any attempt to serve the health needs of low-income rural people.

Law students were included in the planning stages of the student health program. They drafted a proposal for a legal component to the health program and set up an orientation program which was conducted in Nashville with the overall project orientation program.

Law students participated in the somewhat amorphous decision making process that was used during the operation of the project. There was no formal decision making structure with requisite responsibilities. Decisions were generally made on the spot by whomever was present.

As conceived by the participating law students, the legal component of the student health project had these general objectives.

1. To provide the health project and local communities with information and advice concerning state and federal programs and institutions which affected any aspect of comprehensive health care.

2. To identify the legal problems, needs, and resources of the rural areas visited and make recommendations concerning these findings.

3. To expose ourselves as fully as possible to health law problems and the unique legal problems of the rural poor as a means of legal self-education.

B. Orientation

The two-week orientation program was preceded by an inventory and canvass of federal and state agencies concerned with different aspects of Appalachian Tennessee. Resource material was collected and interviews with agency officials were held to inform them of the nature of the of the project and to familiarize ourselves with the operation of their programs.

The Tennessee Department of Public Welfare provided us with copies of the state welfare regulations. Additional resource material included the Social Security Act, Medicaid regulations, pamphletes on food stamps and school lunch, and information on strip mining and reclamation. Howard Thorkleson, of Mountain Legal Rights Association, Prestonsburg, Kentucky, supplied us with valuable studies pertinent to Appalachian legal problems. This material served as a working library during the summer.

The legal orientation introduced all members of the project to the many state and federal social welfare programs and identified particular problem areas we expected to meet. For the law students, the orientation period was used to plan the operational program for the summer, assign people to different geographic areas, and research and further familiarize ourselves with the problems we were to encounter. Short synopses of the operation and regulations of important assistance programs were prepared and distributed to the undergraduate follow-up personnel. Several sessions were held with this group to explain administrative procedures, methods of determining eligibility and benefits, and the rights of applicants and recipients.

Small seminars and large group meetings were held with resource people to give us an opportunity to share their knowledge and experience, to examine the practicality and function of our program, and to delve into different aspects of the life and institutions of the Appalachian people.

A summary of the law oriented speakers is contained in Appendix A.

Recommendations

1. The pamphlet prepared this summer on rights and benefits to state and federal assistance programs should be read and discussed by all project participants prior to orientation.

2. The general structure and format of the orientation program should be used again but with less emphasis on examination of our program and more concentration on particular problems which could be studied during the summer, i.e. effects and problems on strip mining, rural law enforcement and administration of justice, and problems and possibilities of comprehensive health planning programs.

C. Operation

1. General Comments

The necessity to service the health law needs of the mobile unit and local communities was recognized

as our first responsibility. Our second concern was the Clear Fork Valley area of Tennessee. The valley was the focus of our recruitment and funding efforts, and local organizations had extended an invitation to the student health coalition. The other areas which the mobile unit was to visit were considered secondary in importance due to their comparative lack of community organization and the implied and express concern of the project for the Clear Fork Valley.

Our tertiary level of concern was the grouping of ourselves in the best manner to remain flexible to meet the needs and problems which we would encounter. We were uncertain what the scope of our work would be in Clear Fork Valley because there had been mention of the need to conduct a land survey of the entire valley. Such a project would have required significant manpower.

Another consideration was the request of the follow-up personnel for the presence or easy access to law students. We decided to place two people with the mobile unit based on the undetermined need of that operation and problems of transportation. The first two locations, Murfreesboro and Smithville, indicated a need for two people to be available to handle medical-legal problems. This was a false indication. At no other location did the demand approach those levels.

Three people were assigned to the Clear Fork Valley based on established contacts and a feeling of obligation to this area. Other factors involved were available living arrangements, indications of specific work to be done in the valley, family conveniences, and the fact that the valley was to be the center for project communications.

One person was assigned to Briceville, Tennessee, which was the site of one health fair and was close enough to assist people in Deer Lodge, Tennessee, or in Clairfield, if the need arose.

During the course of the summer the mobile unit was attended by at least two law students at each location. One community, Sneedville, had little access to a law student other than during their health fair. Murfreesboro and Smithville received several follow-up visits.

II. OBJECTIVES AND ACCOMPLISHMENTS

A. Objectives and Assessments

During the orientation period we drafted a list of general goals and objectives which we thought should be achieved as a result of this experience. These objectives were necessarily general due to the overall uncertainty of our reception in the local communities and of our ability to function in a legal capacity. During the summer we did not consult this list to redirect our efforts based on our preconception. Instead, we reacted to what we considered the needs of the communities or the circumstances. Consequently, this list and the exercise of formulating it represent more a technique for giving us a direction rather than concrete goals.

The objectives will be listed with accompanying comments as to the practicality and achievement of each.

1. To develop in the people of the community an awareness of their health and welfare rights.

This objective served as our primary function during the summer. Most of our efforts were spent in educating and informing the people with whom we spoke as to their health and welfare rights. Our problem was and will remain: how to reach larger segments of the community and not just individuals with specific problems. The need to expand their education on a community-wide basis can best be served through the local health clinics and councils. The continuity provided by having law students work with these clinics should provide the basis for a future effort at training community people as health law workers. This possibility will be further explored in Section III.

Most of the people with whom we spoke had little understanding of their health and welfare rights. This lack of knowledge was compounded by their suspicion of us and imbred reticence. Consequently, there was no ground-swell of enthusiasm on the part of local people to learn about these rights. But considering that many people in this region depend on governmental largesse for their survival, the need for the awareness of health and welfare rights is apparent. This awareness will not spread rapidly but it can be nurtured through the Rights and Benefits pamphlet and continued law student contact with these communities.

2. To accumulate pertinent information which will be used to attract legal assistance to the area.

This objective was not accomplished outside of general observational comments which can be made, and are contained in this report, as to the need for legal assistance in the Clairfield area. The mobile unit gave us the requisite exposure to collect such information, but the legal questions were excluded from the medical questionnaire administered to approximately 7500 people. These questions (Appendix B) or similar ones should be used to assess the availability of legal assistance from the local bar.

A working relation has been established with attorneys of the Appalachian Research and Defense Fund, Inc. who have offices in nearby Barbourville, Kentucky.

3. To provide information concerning federal, state and local assistance programs and to assist local people in recognizing problems and developing solutions to them.

This objective is the mechanical implementation of Objective 1: to develop an awareness of health and welfare rights. Through the research we did in Nashville and the material we collected, we were able to provide information and advice regarding health and welfare problems to most people who sought it. Our Rights and Benefits pamphlet which will be distributed to key community people should serve as a continuing source of information.

The development of para-professional health law workers is a long range task. The brevity of our stay did not permit the development of those pre-conditions of identity and confidence which would foster such training. Added to the problem of developing trustworthy relationships is the factor of relatively low education levels and the need for remuneration. However, the existence of health clinics and councils provides the requisite organizational structures through which recruitment and training of health law workers could be achieved. A continuation of this summer's program would be valuable in creating the impetus for developing these workers.

4. To observe problem solving techniques of other disciplines in an attempt to broaden our perspectives and to maximize the efficiency of the interrelationships of the disciplines.

While law students developed an appreciation for the problems confronting health care delivery in rural areas, there was no meaningful exchange between students on the level of their disciplines. This was a necessary result of the need to serve large numbers in the communities and the organizational deficiencies of the program.

If future programs operate at a more thorough and slow pace, law and medical students could pursue common problems. The development of better health care delivery systems requires inter-disciplinary cooperation beyond that apparent this summer.

5. To educate ourselves on social welfare laws and their application in practice.

This is the most practical goal and one which we successfully realized collectively. Our group was very knowledgeable about governmental assistance and capable of solving most problems with which we were confronted.

6. To observe the attitudes of a rural mountain people toward the system of law unique to the area.

This is a valid objective because the attitudes of the people toward the law and practicing attorneys should be considered in recommending a program for legal assistance to this area.

We were not exposed to enough people to be able to comment competently on their attitude. We came away with the impression that the people are highly suspicious of the workings of the law and do not trust attorneys because they fear financial injury from participating in the legal system.

The questionnaire (Appendix B) drafted for use this summer could be used to determine the nature of the people's attitude toward law. However, one of the problems this type of study creates is an interference with the trust and confidence that the law student is trying to create with the local resident. If the questions can be asked as part of a large series of questions, their probing nature can be minimized. The attitude of the people is a crucial element in assessing the standards and quality of the legal profession and the law in rural America.

7. To document and interpret institutions which affect the area.

While we have identified the institutions of the area we have not documented or interpreted these institutions in any acceptable form. To get more than a sense impression of local institutions, it is necessary to work closely with the local people. Unless one is exposed to the home experience, it is difficult to obtain their observations while attempting to create an aura of trust.

B. The Tangible and Intangible Pay-Offs

The Personal Experience

It is inappropriate to attempt to capture the personal response of each member of our group in a first-person plural report. The personal reactions can be culled from the descriptive section in Part I. There are, however, common responses to this experience which can be set forth in general terms without losing too much of their meaning.

The intangible effects of the summer are a sensitizing of the individual on a personal and professional level as to the life, conditions, and problems of Appalachian people. The exposure to rural poverty and observations of the institutions which have maintained this life and the ones which struggle to change it are the sources of this sensitivity. Yet, their awareness is wasted if it is not translated into some form of constructive action. This action is noted further in this section and in the recommendations of this report.

The effect of this program on the local communities is difficult to assess. Undoubtedly, there has been increased interest and concern for matters of health on the part of the community at large and increased individual awareness of certain health rights. There has also been a positive exposure to youth working creatively at a time when youth is under heavy criticism for its use of violence.

Referral Services

We assisted approximately 200 people with differing problems from the loss of Medicare coverage to the obtaining of eye glasses. We aided many elderly miners in their efforts to receive compensation for the chronic chest disease, black lung. The variety of problems was considerable and too lengthy to catalogue.

Rights and Benefits Pamphlet

A pamphlet explaining the procedures, benefits, and rights of significant governmental assistance programs was prepared and is being printed for distribution in the communities. The topics covered are welfare, Medicaid and Medicare, Social Security, food stamps, black lung benefits, workmen's compensation, unemployment compensation, and veterans benefits. This pamphlet will be given to community people who have extensive contact with others in the community such as preachers, postmen, and merchants.

Student Projects

As a result of this experience, law students have undertaken the following projects:

A paper dealing with the rights of low-income people to access to federally funded Hill-Burton hospitals.

A paper concerning problems created by strip mining and suggesting remedial legislation.

A paper analyzing the legal problems of Appalachian people and recommending a legal program to meet these needs.

The development of an interdisciplinary seminar in conjunction with Vanderbilt's Urban and Regional Center dealing with the delivery of health care.

A canvass of attorneys in the Clairfield area to determine their conception of the area's legal problems, their efforts and willingness to assist low-income people. (Appendix C)

III. ANALYSIS AND EVALUATION OF LEGAL PROGRAM

This evaluation attempts to synthesize the elements of previous sections to identify as precisely as possible the actual role or function of the law students in the Student Health Project, what the project contributed to the law student, and what realistic conclusions can be drawn about feasible and effective continuation of law student participation in this project.

There are two underlying questions which are being considered in this section. One question is whether or not

there are sufficient benefits for local communities, the health project, and law students to urge continuation of this program. The second question, premised on an affirmative position on the first, is: in what direction and what form should the program continue?

A. The Role of the Law Student in the Student Health Coalition

The primary role of the law student was to serve community people as an informational resource on a wide range of social welfare programs. This role included providing technical assistance to local community organizations.

The secondary role of the law student was an unofficial ombudsman hearing the complaints of people and when necessary interceding on their behalf with the appropriate administrative agency. This role included bringing to the attention of administrative agencies cases which presented no controversy but needed prompt attention.

The tertiary role of the law student was as a resource to the overall health project in terms of information, advice, and point of view on matters relating to the law.

B. The Role of the Legal Program in the Education of the Law Student

While this segment repeats a previous section about personal experience, it bears reemphasis because of its importance in evaluating the benefit of the legal program.

The contribution to the students' legal education cannot be measured by the standard criterion of legal understanding, analysis and expression, though these facets are not absent. The legal program provided the opportunity to become very familiar with social welfare law and its actual operation. The student was exposed to the conditions and poverty of the welfare recipient, the problems of welfare case workers, and the workings of the welfare department. The student observed the functioning of legislatively-established institutions such as TVA and the Appalachian Regional Commission and could measure their value and effectiveness from the standpoint of the citizen consumer.

The law student observed at firsthand the social institutions that shape the lives of rural poor people and learned from the people the significance and failings of these institutions. The difficulties involved in communicating with people about complex social welfare laws require clarity and conciseness of expression.

The law program provides the law student with a meaningful alternative to the usual summer experience as a clerk in a law office. The student faces the immediate and personal needs of people and is sensitized to their problems. The impact of this personal experience as opposed to the more structural law-office experience should pay off in the future direction and interest of the student.

C. Conclusions as to Functions and Benefits of Law Program

1. Law students provide a definite contribution to the Student Health Coalition and to citizens in the communities the project visits by providing information and explanation of vital supportive social welfare programs. In addition, individuals who have had little contact with law are exposed to the law in a setting which is personal and attempts to work for their benefit.

2. The legal program is limited in its capacity to deal with the broader range of legal problems which effect the poor. While the law student can offer informal advice and in some cases direct an individual to a qualified attorney, the legal program does not have the requisite legal connections to permit taking actual controversies into court.

   The brevity of the law student's stay in the community is another factor which prevents enlarging the scope of the legal program. A two to three month period is not sufficient to identify, develop, and follow-up a legal problem. The distance of these areas from Nashville does not allow for effective communication or resolution of problems.

   The legal program can attack some of the legal problems of the poor by giving technical assistance to community organization. While this route represents an indirect approach to the problems, conditions are such that the indirect approach is probably best. For example, the most practical solution to improving housing is not by attacking landlords in the courts, but by providing alternative and standard housing.

3. The law program can become an effective research and study group of legal, environmental, health law, and institutional problems of Appalachia. We did not pursue this approach, because we spent our time

providing information and organizing community health councils. Any research effort should be aware of possible suspicion and hostility of highly visible studies and weigh the value of the study against the value of maintaining community trust and confidence.

4. Continuity of the legal program is important to the development of legal assistance for the poor in Appalachian Tennessee. The knowledge and experience developed by this program should be utilized to attract some manner of legal assistance or aid in the creation of complementary programs, such as the para-professional or the health law worker.

IV. RECOMMENDATIONS

1. The cooperative relationship with the Student Health Coalition built around the health fair concept should be continued. The legal program should place more emphasis on community involvement with health clinics and local organizations.

2. The relationships with the communities of Briceville, Clairfield, and White Oak should be continued in an effort to establish a framework for future legal assistance. Established contacts with legal organizations in Kentucky and Tennessee should be maintained, and contacts with county bar associations and new community projects and organization should also be initiated.

3. A major project for the summer should be selected for all law students to work on. The topic can be selected from consultation with last year's students and preliminary work can be done in the spring. The faculty adviser can guide the research and arrangements should be made for publication as a law review note or in a journal pertinent to the topic.

4. The internal structure of the Student Health Coalition should be formalized to provide identifiable sources of control and responsibility. An agreed upon decision making process should be established, and different groups within the project should be represented in the decision making body. Consideration should be given to the appointment of one or two people with the sole function of coordinating the project and handling internal communications.

A more detailed commentary by the law students on their projects appears in the Appendix.

Nurse-Practitioner Training Program

Betsy Weil

Moved by a need for increased exposure to nursing among rural populations and sensing the necessity of being maximally prepared for such a role, the eleven nursing students involved in the Student Health Coalition underwent training beyond the conventional nurse's training before embarking on the summer's tours with the mobile unit. Of the eleven nursing students, five were graduated and the remaining six were approaching their final year of nurse's training at Vanderbilt Nursing School; all, however, felt the heavy pace of summer's work, as well as the environment in which they would be performing, would require training in physical screening, improvisation in working materials, and at least cursory acquaintance with fields of medicine ordinarily excluded from nurse training.

Preparation for the summer's work began in early spring of 1970. Nursing students participated in a Red Cross home nursing course, intended to aid the clinical nurse in adapting to rural environmental situations and to improve nursing skills in the home situations. In late spring, nurses attended prenatal clinics and classes on emergency care in labor and delivery.

During the orientation period just prior to the summer project's start, the nursing students attended classes in physical diagnosis and history, taught by Dr. Amos Christie and attended also by the medical students in the program. By also attending family-planning, prenatal, and well-baby clinics, nurses received a thorough three-week indoctrination into diagnosis and history to enable them to become primary screening agents during the summer's work in health fairs.

For all the nurses concerned, the role of the primary screening agent was entirely novel. Their job, along with that of the medical students, was not to diagnose, but simply to determine what was abnormal versus normal in a patient and to seek consults for abnormalities. Such a role saved the time of physicians at the fair and gave the nurses valuable training in perceiving the subtleties involved in actual physical diagnosis.

On the mobile unit, one nursing student performed adult women's physicals; three graduate nurses and one nursing student performed pediatric physicals. On the laboratory unit, one graduate nurse and one nursing student worked, drawing and processing blood, running x-ray and EKG machines, and compiling

audiograms for those in need of them.

Two junior nursing students worked with the nurses in the Clairfield Clinic in Clairfield, Tennessee. Their work included screening, limited treatment, and much organizational help in the follow-up aspect of the summer project in the Clairfield area.

In the actual follow-up portion of the program, one graduate nurse and two student nurses performed follow-up visitations and applied follow-up organization and coordination in a total of four communities. The graduate nurse, as general coordinator for medical follow-up, "floated" to differing communities and aided in the primary organization of follow-up with the follow-up personnel residing in each community.

Evaluation

Despite the rigorous two-week training course in physical diagnosis and history, nurses involved in the primary screening at times felt ill-prepared to handle certain complex medical situations that arose. Several commented that they feared that they were missing certain subtle clues to pathology that a person of more experience might pick up. However, all noted that, as the summer progressed, so did their abilities to determine abnormalities in the patients they screened.

Regarding training, the nursing students felt that the Red Cross Home Nursing Course and the prenatal clinics, while informative, were generally a review of nursing skills and, in light of other needs in diagnosis training, were a waste of time.

The Vanderbilt School of Nursing is in the process of formulating a graduate program in the Family Nurse Practitioner. This program will begin in September of 1971 and is using this coming year for planning. One nurse from the summer project has remained in Nashville, under the title of Student Nurse Consultant, to aid in the development of the program.

Brief Statement Concerning "Nurse Practitioners" as They Functioned in the Vanderbilt Student Health Coalition's Project in Appalachia During the Summer of 1970.* (Joe Moss, Jr., M.D., Assistant Professor of Pediatrics, Vanderbilt University School of Medicine.)

I.

The personnel discussed in this report are, for the most part, upper class students in the Vandervilt School of Nursing or June 1970 graduates of this same school. All are candidates for the R.N. Degree. All participated in an intensive three to four week orientation course where many of the skills used during the summer were taught or reviewed.

Focusing on the mother-child unit and using the tools of history taking, physical examination, and some basic laboratory data, the nurse's objective was to perform a thorough pediatric evaluation on each child presented to them. This evaluation had several obvious components. First, to identify disease in the broadest sense of the word. This meant not only organic or purely physical problems but more difficult developmental and sociological illness. Second, an 'in context' assessment had to be made as to the significance of the disease and how it influenced the patients life; this often entailed insight into varied sets of socioeconomic standards. And last, the examiner had to recommend, and often initiate therapy or any further pursuit of the problem. The situation frequently involved practical barriers or the need for unavailable resources.

II.

As "nurse practitioners" performing the above evaluation, several areas of competence are noteworthy. The fundamentals of physical examination were learned and employed on an especially satisfactory level. Not only were fairly straightforward specific problems identified, but more subtle entities such as chronic illness, malnutrition, anemia, etc., were handled with impressive perception. Only the most complex organic entities seemed to reach beyond the grasp of the nurses; yet even these problems, such as cardiac, orthopedic, or neurologic derangements, were spotted easily. In short, it can be said that with few exceptions children were noted to be normal on examination or their specific maladies were brought to further attention.

Many children presented, as might be expected, with acute illnesses which warranted immediate attention. Again, a notable degree of clinical competence evolved during the summer as these nurses learned to cope with and make accurate diagnostic and therapeutic decisions regarding many common childhood problems

(i.e. respiratory infections, otitis, impetigo, rashes, etc.). They were serving, in fact, as primary practitioners under, of course, appropriate supervision.

Additionally, information and advice about matters of fundamental import to well child care such as preventive medicine and the broader horizon of family and community health were handled with alacrity and effectiveness. Infant rearing practices, immunizations, interpersonal relationships, sanitation are specific areas where the nurses of the Student Health Coalition demonstrated their abilities. It should be suggested that a well-rounded nursing curriculum possibly prepares an individual better for community medicine than does an equivalent level of medical training.

Finally, young nurses seem to have an enthusiasm and easily establised rapport with mothers and children that cannot be overemphasized in its importance.

III.

Several areas of performance must be subjected to critical review. The most serious deficiency in the screening program of this past summer would have been obvious to any well-grounded clinician. Specifically, the fundamental art of history taking was utilized poorly. Experience is necessary to take a history, interpret it, and realize its potential. This experience and the clinical maturity gained from it accumulates slowly in one's medical training. This fact was accentuated in this summer's activities. Greater emphasis on the history should be incorporated into the preparation for future health projects.

Going considerably slower than a seasoned examiner, the nurses were not as efficient as might be desirable. This diminished the service rendered but was acceptable in the light of teaching value.

Significant differences were seen between individual "nurse practitioners" as far as their abilities, self confidence, aggressiveness, etc. Much of this variance stems from working in a relative vacuum of knowledge, i.e. lacking background in pathophysiology, human development, etc., rather than any differences in basic talent on their part.

In considering future "nurse practitioner's" roles, many questions are unanswered. Can a nurse become more efficient yet maintain quality? How loose can medical supervision be? How much and what type training is necessary for the particular role? Much effort will be made to develop adequate training courses.

However, equally important in a situation where tremendous responsibility is given to someone only partially trained in a particular specialty is the factor of personnel selection in an effort to maintain a level of high motivation. This is the force that closes any gaps, i.e. pushes the "nurse practitioner" to improve her skills, to conscientiously pursue problems confronted, and maintain quality in adverse circumstances.

IV.

In summary, this physician's attitude is a very optimistic one as far as what the role of a "nurse practitioner" might be in future health care delivery systems. This attitude is based in the majority on the experience gained with the Vanderbilt Student Health Coalition's summer project under innovative and often difficult working circumstances that inherently exist in any "pilot project." A hoped for and logical sequela to a project of this type would be the establishment of effective training programs for production of more sophisticated "nurse practitioners" and the reciprocal opportunity to provide their services wherever the need is greated.

*It should be recognized that this is largely a subjective evaluation by the pediatrician, hopefully not too prejudiced, most closely associated with the project on a continual day-to-day basis. I do not believe that a more objective statement can be made about the subject matter discussed, although this may be possible in the future. Brevity rather than elaboration was a prime goal. Generalizations have been made. Many major aspects of the summer 1970 program were not introduced and must be discussed elsewhere.

Definition of Family Nurse Practitioners
Vanderbilt University School of Nursing
September 4, 1970

A professional nurse who by virtue of a formalized program of study is qualified to expand her nursing practice as the model of clinical expertise in family nursing. She determines and facilitates the application of preventive health measures, and she manages selected deviations from wellness with diagnostic and therapeutic actions in a specified population. She may do so autonomously by (1) assessing, diagnosing, and treating; (2) assessing, seeking consultation and treating; and (3) by referring to appropriate specialist for further diagnosis and treatment. She will function within established plans of health care management agreed upon by nursing and medicine. She constantly evaluates and alters her practice in light of advanced and current scientif knowledge and community needs and demands. As an advanced clinical speialist she demonstrates her advanced scientific knowledge and her skills in the area of research. She is articulatein her verbal communications and in publications. She assumes leadership responsibilities in the health care system and in the profession. She carries out her leadership role in consultation, teaching, and management of care for families and communities.

Within the professional community of nursing and allied professions, she collaborates, coordinates, and becomes emersed in activities related to her primary responsibility - the improvement of the quality of nursing health care to people.

The preparation of the family nurse clinician is on the master's level.

Mental Health Program

A mental health component was added to the summer project almost as an afterthought during the late spring. It was hoped that this effort would add to mental retardation services in its target areas, but the project was conceived as primarily exploratory for this first summer, looking into the nature and extent of the problem, available services, and needs. It included three students.

The three weeks of orientation were spent in Nashville educating ourselves about mental retardation and mental health and services that might exist in these areas; learning to administer the Denver Developmental Screening Test (DDST); learning about the culture of the areas where we were to work; and formulating goals and plans.

We originally planned to focus our efforts on the Smithville and Clairfield areas. Thus, the first two weeks out of Nashville were spent with the mobile unit, testing children in Murfreesboro and Smithville. Our testing there revealed extremely few children significantly below the test norms. Moreover, the area is a prosperous one with a broad range of services available. Consequently, we determined to alter our plans and concentrate on Briceville and Clairfield. One student, Linda McFadyen, then went to Clairfield, where she remained all summer. She administered the DDST during the health fair. Few enough children attended this fair to enable her to follow up on children showing deficiences by working with each one individually almost every day. Adolescent girls from the area often accompanied her and were able to learn to use techniques such as operant shaping. Further, they expressed the desire and intention of carrying on her work with the children after she left. Family members, both parents and siblings, in homes that she visited exhibited the same reaction and soon were spending considerable amounts of time working with their children. During her stay in Clairfield, Linda lived with a family of seven in a two-room house, which also sheltered frequent family visitors returning from urban centers in the South and Midwest, to which they had immigrated in search of employment, a better life, or for other reasons. She thus had ample opportunity both to observe family life and to talk with returning mountain people.

Meanwhile, two of us were in Briceville. Until the health fair we spent our time surveying services related to mental retardation and acquainting ourselves with the community, as it

was acquainting itself with us. Our orientation to the community was facilitated by the fact that two follow-up workers and a law student had preceded us there. During the health fair we administered the DDST and were on several occasions approached for help with adult retardates or behavioral disorders. With approximately 1200 participants, almost 600 of them children, this was the largest fair of the summer. Since our testing indicated a high percentage of retardation, the two of us were unable to work individually with children. Instead, we could only visit each home for a retest and appraisal of the home situation and then make referrals, where possible, to the appropriate agency. This procedure often gave us an opportunity to see shortcomings in such agencies from the viewpoint of the consumer, especially the indigent consumer. It is interesting to note that virtually all of these agencies are located in Oak Ridge or Clinton, two islands of affluence in an otherwise disadvantaged county. People in the hills have a particular distrust and resentment of Oak Ridge, and they told us that the high average income in Oak Ridge made the county ineligible for the food supplement program. Whether this is, in fact, true is less important than the fact that the mountain people believe it and that they need this food program.

A number of factors appear to bear on the retardation that was observed by members of our group. One of these is education. A high proportion of the teachers in these areas are poorly qualified, for reasons of age, incompetence, lack of education, emotional problems, etc. This is not to say that there are not some dedicated and able teachers, but that the number of such people is too small. The less able teachers are allowed to remain in their jobs because it is extremely difficult to attract replacements for them. (1) The pay scale is low, since local revenue is low and most of what there is goes to the more prosperous or politically powerful parts of a county. (2) Also, transportation is almost as poor for those teachers who would commute to school from a city as it is for the students. (Incidentally, many of the roads are in such bad condition because of the constant traffic of heavy coal trucks, most of which display no license tags that would indicate that they have at least contributed that much toward upkeep of the roads) (3) Finally, there are few jobs to attract men whose wives might have the qualifications and desire to teach.

The drop-out rate in some counties reaches as high as 35 and 40%, implying a drastic need for curriculum improvement, among other things. Funds for vocational or special education

teachers are allotted on the basis of average daily attendance (ADA) which typically is lower in rural areas because of transportation problems and duties of children at home. Further, many schools are small--2 to 5 teachers--and have too few exceptional children to justify special education, indicating possibly a need for more consolidated schools. One of our most distressing observations was that some teachers become hardened to disadvantaged children and ignore their special needs, fail to refer them when help is available, or scoff at the efforts that others may make, an attitude that children do not fail to notice.

Other barriers to the proper development of children seem to lie in the family and home situation.

Housing

1. Houses are generally too small for the family size.

2. Some homes have no running water, and most lack indoor toilet facilities.

3. Water in many streams and springs is polluted due to strip mining and improperly located outdoor toilets.

4. Outdoor toilet facilities are generally unsanitary, thus contributing to intestinal worms.

5. Homes are often poorly insulated and constructed of substandard materials.

6. Insects, rats, chickens, and pigs are often found in the homes. It is difficult for the residents to get help in eliminating the rats, though they have tried repeatedly.

7. Garbage disposal areas are scarce. Consequently, some people must save their garbage and dump it periodically over a mountain. Others create individual dumps, which they burn occasionally. This practice contributes to the rat problem.

Child-rearing practices

1. The child experiences little routine or consistency in the events of his daily life, such as meals, the father's return from work, baths, etc.

2. Overt father influence is absent in childrearing. There is little or no show of affection from fathers;

fathers rarely babysit to free their wives for other tasks; fathers are rarely present at the birth of their children; there is little verbal interaction between father and child. When this latter does occur, it is usually for a punitive nature.

3. The level of verbal activity is low. Language is used primarily for punitiveness and household management. We know that school achievement correlates positively with "school language" ability. "School language" is defined as language used to note, describe, compare, contrast, abstract, sequence, narrate. First graders from disadvantaged homes lack the ability to use language in these ways. For this reason, reading and language skills are soon deficit areas, rarely overcome in remedial programs.

4. There is a low level of learning interaction between mother and child. This is probably a function of large family size and of the inexperience and low self-confidence of mothers. Most mothers lack the self-concept which would allow them to identify themselves as someone knowledgeable enough to teach children. The child deprived of this mother-child learning experience does not learn to perceive himself as someone who can learn. Also, this lack of attention-focusing experience results in a child who is distractible and cannot attend to any single task for long. This is devastating when the child enters school. We saw this lack of learning interaction as one of the most serious problems of the people with whom we worked. Because parents and siblings initiated our behavior in working with their children, we believe they would be receptive to a program teaching them to teach their children.

5. Behavior control is attempted mostly through physical punitiveness. Mothers need an understanding of more positive behavior control techniques, such as some form of operant conditioning.

6. The way in which children are defined or valued by disadvantaged mountain families is seen as relevant to development of the children.

   a. There seems to be some hangover from the days in which large families were necessary for existence. Indeed, difficult living conditions even today would seem to confirm this view. In this sense,

children are still viewed as commodities. Individuality cannot be fostered in such a situation because it tends to be disruptive.

b. Children are sometimes viewed, paradoxically, with both hate and love. They are loved as the embodiment of hope but hated as the extensions of mother, since many mothers have no love for themselves.

c. Children are viewed also as "someone I can depend on in my old age." Parents lack the security to allow their children independence to break the cycle of poverty.

d. A number of fathers are frightened by their own sexual feelings toward their daughters and seek to avoid "sin" by withdrawing from all affection and interaction with their daughters.

Nutrition

1. Some families simply could not get the money or transportation to go to buy food stamps or pick up supplemental food on the one day per month that these were available. At the very least, more frequent food days would be advisable.

2. Many people who were aware of which foods are most nutritious still continued to buy junk food, which was often more expensive. Apparently they are either unaware of the importance of nutrition or they just did not like nutritious foods, a strong possibility in view of their limited experience with different foods.

3. A typical diet would include beans, cornbread, cream gravy, fat meat, soft drinks, cake, and snack food.

Mental Health of Parents

1. A great many of the fathers were alcoholics by the age of thirty. They followed a pattern of drinking with groups at their male age-mates with increasing frequency, so that the group pulled each of its members down over a period of several years.

2. An important characteristic of the culture is a kind of avoidance-as-a-life-style behavior pattern. This is rather predictable since to confront all aspects of a

life of poverty would be impossible and since the few attempts at change usually fail. This history of failure and the overwhelming flood of daily problems preclude any sense of direction and contribute to what the outsider often perceives as lethargy. A mother cannot simply ignore or avoid her problems, however, and the pervasive and lifelong pressure for essentials causes in many women an anxiety that can be disabling.

This, then is what we saw. Our recommendations follow.

1. An effective support and incentive program should be implemented to help young people, both male and female, from disadvantaged mountain areas to become teachers and nurses and to encourage them to remain in the mountains to work. Some teachers from other areas should also be attracted. We believe this is possible and it is certainly worth trying.

2. Transportation, especially to outlying areas, must be improved and maintained.

3. Service agencies that already exist should make every effort to improve their understanding of and relationship to the communities they serve. Their staffs should be increased to enable them to devote more time and personnel to home visits, especially in those cases where families have no transportation available.

4. Methods should be established for the early detection of retardation and emotional problems and for dealing with these problems as they are detected. Such action will require a substantial increase in facilities and personnel. Public health nurses could be used in this task.

5. Indigent groups should be encouraged and aided in their efforts to organize self-help programs. One offshoot of such organizations is increased influence with the county seat and its allotment of funds.

6. A program of community mental health education should be undertaken to increase awareness and knowledge among mountain residents.

7. Conversely, mental health personnel should be educated concerning the mountain people and their special needs.

8. Programs should be undertaken for control of floods, rats, and pollution.

9. Teachers and principals should be made more sensitive to the need for detecting and dealing with emotional and retardation problems before it is too late.

10. The number of speech therapists attached to the schools should be increased and their working relationship to classroom teachers should be improved.

11. Funding agencies should be willing to spread more of their money into the outlying areas, as opposed to "growth centers," exchanging large showpiece results in populous areas for smaller but badly needed projects to serve those families who choose not to live in urban areas or could not support themselves there.

12. High school curricula should include more courses of vocational orientation to give their students needed preparation for jobs and the skills they will need if they attempt to move to cities.

13. County nutrition councils should have salaried directors with social work orientations. These officials should take advantage of existing agencies and available volunteer workers and direct their efforts toward making good nutrition a right of every child and pregnant mother. Three possible activities would be nutrition classes or clubs for disadvantaged mothers, organized transportatiom to these classes and to food stamp centers, and the improvement of water resources in areas without purified water.

14. Public Health Departments in every county should provide free prenatal clinics for the indigent. This is a basic and obvious deficiency that has yet to be eliminated in many of the poorest counties.

15. Finally, we recommend that a system of day care centers be instituted, at least in poverty areas. It should place strong emphasis on parental participation: consulting parents on what is to be taught, using parent-aides in the centers, and working toward meaningful and productive parents' organizations. Regular home visits should be made for every child, to integrate

more effectively the child's education at home and at the center. Facilities and personnel should be available through the centers to cope with the full range of family problems, including medical and psychological problems.

16. In setting up day care centers or in any other steps that may be taken, it is absolutely essential that representative members of the communities concerned be actively involved at every stage, from planning on. Such involvement would lower barriers to implementation and increase the usefulness of the end product. On the other hand, to ignore the counsel of the community, either deliberately or through negligence, is to risk the waste of badly needed funds and talents and to display a clear contempt for people who want to help in solving their own problems.

DRINKING WATER QUALITY IN THE CLEARFORK VALLEY, TENNESSEE

Summary

This study was carried out because the authors had been informed by Dr. William Schaffner, Department of Medicine, Vanderbilt Medical School, that infectious hepatitis was fairly common in the Clearfork Valley, in Campbell and Claiborne Counties near the Kentucky-Tennessee state line north of Knoxville. Among the approximately 5,000 people living in the valley there are a number of cases of hepatitis each year. Typhoid is said to occur in the general area; at the time this study was initiated three reputed cases were being treated in Tazewell, a short distance to the east of the Clearfork Valley.

During the period 6-9 July, 1970, approximately 100 samples of drinking water were taken from well, spring, and branch supplies in the Whiteoak-Eagen-Clairfield-Hamblintown area of the valley; total coliform bacteria counts were taken on these samples. It was found that the quality of the drinking water in the area was generally quite bad--these water supplies constitute a serious hazard to the health of many of the people living in the valley, and the degrees of fecal pollution demonstrated to be present are more than adequate to account for the incidence of infectious hepatitis and other water-borne diseases. The causes of this pollution include leaky well casings, inadequate coverings on open wells, cracked well platforms, the location of privies in the vicinities of wells and springs, unprotected springs, polluted drainage ditches in the vicinity of wells and springs, improper operation of chlorinators, and unknown sources of contamination.

We estimate that roughly half of the sources of drinking water in use in this area are polluted with feces(human or animal waste). We therefore urgently recommend that families living in the area disinfect their drinking water by treating it with hypochlorites such as Purex, Clorox, HTH, etc., or by boiling, unless recent testing has established that their water source is free from contamination. We also suggest that these communities investigate the development of other drinking water sources--perhaps the construction of public town wells and distribution systems, or facilities for treating stream water and distributing it, or arrangements for trucking drinking water into the valley. We urge the immediate relocation of all privies located in the vicinity of wells, the protection of springs used as drinking water supplies, and location and construction of future wells in a way consistent with the principles of sanitation.

Background Information

Water polluted with undisinfected fecal matter (human wastes) can transmit the following diseases: typhoid, the paratyphoids, viral hepatitis, dysentery, amebiasis, polio, and a number of viral gastrointestinal illnesses causing diarrhea, vomiting, and other symptoms.[1] The organisms (germs) responsible for at least some of these diseases are routinely found in undisinfected sewage in urban areas, and can be expected to occur sporadically (now and then) in human wastes in rural areas. Coliform bacteria, a non-harmful group of organisms, occur in the intestinal tracts of warm-blooded animals in enormous numbers, and are therefore very commonly used as a test organism to determine whether or not a sewage effluent (outflow) is properly disinfected, or whether or not a stream, lake, or water supply is polluted with undisinfected feces. To test for these coliform organisms, we use the

membrane filter method used and recommended by the Federal Water Quality Administration for the determination of total coliforms (the concentration of coliform germs present in the water).[2]

The U.S. Public Health Service has established bacteriological standards for drinking water; these are as follows: "When the membrane filter technique is used, the arithmetic mean coliform density of all standard samples examined per month shall not exceed one per 100 ml. Coliform colonies per standard sample shall not exceed 3/50 ml, 4/100 ml, 7/200, or 13/500 in (a) two consecutive samples; (b) more than one standard sample when less than 20 are examined per month; or (c) more than five percent of the standard samples when 20 or more are examined per month."[3] That is, the occurrence of any appreciable number of coliforms in the water means that it is not regarded as fit to drink without treatment. We note that the government standard is set for total coliforms, rather than fecal coliforms as measured by the elevated temperature membrane filter method.[4,5,6,7]

Procedure

The recommended precautions for sampling were followed wherever applicable[8], and the samples were filtered within four hours after being taken. The filters were incubated at 37°C (98.6°F) for approximately 20 hours and then examined for the occurence of colonies showing the characteristic green sheen. Initially, 200 ml samples were used; it was found that these frequently led to colonies which were too numerous to count, after which 25 ml samples were used. Frequently these led to colonies which were too numerous to count, also. All glassware, filters, etc., were autoclaved for at least ten minutes at 15 psi, or boiled for 20 minutes. Check samples of boiled cooled water showed no growth whatsoever. MF Endo medium and standard equipment were used.[5] Initially the samples

were iced during the time between collection and filtration; later this was not possible, and they were kept in the shade in a well-ventilated car. Generally only one sample was taken from each source, although in some cases repeat samples were taken either as a check or if a significant change was thought to have occurred in the supply (repair of a chlorinator, for example).

Results

The results obtained are summarized below according to town; results on individual sources were reported to persons using the sources and the notebooks in which these individual data were logged are available for inspection provided that the privacy of the individuals concerned is maintained.

Table 1. Bacteriological Quality of Drinking Water Sources According to Town

Town	Acceptable	Questionable	Polluted
Hamblintown	14	9	8
Clairfield	4	1	12
Eagen	2	0	1
Roses Creek	0	1	7
Habersham	2	2	12
White Oak	5	1	15
Total	27	14	55

Rural homes and small hamlets are included in the nearest town. Sources listed as acceptable yielded no more than two coliforms in a 25 ml sample--a

slightly more lax standard than that recommended by the Public Health Service. Sources listed as questionable yielded from two to ten coliforms in a 25 ml sample. Sources listed as polluted yielded over ten coliforms per 25 ml; by and large, the colonies grown from samples from these sources were too numerous to count.

Causes of Contamination

Quite a number of possible causes of contamination of water supplies were seen. Springs were usually not protected from surface drainage, and were often not protected from contamination by people or animals. Wells were observed with leaky gaskets and probably leaky casings, with inadequate covering on open wells, with cracked well platforms, etc. Privies and polluted drainage ditches were observed in the vicinities of some wells and springs. In two cases, chlorinators were inoperative. We were also informed that in periods of flood some wells were filled with surface water.

We note in passing that we observed a number of extremely well-designed and well-constructed domestic wells, and that most of these wells appeared to be quite acceptable sources of drinking water when tested.

Sources of Information on Individual Water Supply Systems

The U.S. Public Health Service has published a very good manual on the construction and maintenance of individual water supply systems; it is available from the U.S. Government Printing Office, Washington, D.C. 20402, at a cost of 40¢.[9] Ehlers and Steel also have a good discussion of these topics, but this book is not so readily accessible.[8]

Recommendations

In view of the large number of polluted water supplies which were found

in the area, we urgently recommend that all drinking water be disinfected either by boiling or by chemical treatment with chlorine bleach unless recent testing has established that the water is free from bacterial contamination. "Vigorous boiling for one full minute will kill any disease-causing bacteria present in water. The flat taste of boiled water can be improved by pouring it back and forth from one container into another, by allowing it to stand for a few hours, or by adding a small pinch of salt for each quart of water boiled."[9] If chlorine bleach (Clorox, Purex, etc.) is used, add 10-15 drops of bleach to each gallon of water, mix well, and allow to stand for 30 minutes. The water should then have a slight chlorine odor; if it doesn't, repeat the dosage and allow the water to stand for an additional 15 minutes. If the treated water has too stong a chlorine taste, allow it to stand exposed to the air for a few hours or pour it from one clean container to another several times.[9]

We further urge the relocation of all privies presently near wells (and springs) to a distance of at least fifty (and preferably one hundred) feet from the well, and to such a place that water does not drain from the privy toward the well. We urge that all springs used for drinking water be properly developed and maintained, as described in reference 9. We urge the establishment of a testing service by the appropriate government agency to provide bacteriological testing of drinking water supplies routinely at appropriate intervals and on request. We urge that schools, public health agencies, and community organizations carry out a program of public education in this area on the hazards of polluted drinking water, that these groups make available copies of the Manual of Individual Water Supply Systems[9] to area residents, and that they investigate the availability of state or

federal support for this program. We suggest that the towns investigate the development of other drinking water sources--perhaps the construction of public town wells, disinfection facilities, and distribution systems; or the construction of facilities for treating stream water and distributing it, or arrangements for trucking drinking water within the valley. The possibility of federal assistance for such development should be studied. We suggest that a survey program be carried out to determine whether polluted wells and springs should be developed, repaired and maintained, or replaced by a new well, properly located and constructed.

References

1. P. E. Sartwell, ed., Maxey-Rosenau Preventive Medicine and Public Health, 9th ed., Appleton-Century-Crofts, 1965.
2. Current Practices in Water Microbiology, Federal Water Pollution Control Administration (FWPCA), 1967.
3. Manual for Evaluating Public Drinking Water Supplies, U.S. Public Health Service, 1969.
4. E. E. Geldreich, The Sanitary Significance of Fecal Coliforms in the Environment, FWPCA, 1966.
5. Techniques for Microbiological Analysis, The Millipore Corp., 1965.
6. P. H. McGauhey, Engineering Management of Water Quality, McGraw-Hill, 1968.
7. Report of the Committee on Water Quality Criteria, FWPCA, 1968.
8. V. M. Ehlers and E. W. Steel, Municipal and Rural Sanitation, 6th ed., McGraw-Hill, 1965.
9. Manual of Individual Water Supply Systems, U.S. Public Health Service, Division of Environmental Engineering and Food Protection, 1963.

Charles Schiff

David J. Wilson, Ph.D.

VANDERBILT-MEHARRY STUDENT SUMMER HEALTH PROJECT
1970

The urban project described herein is the outgrowth of an offer made by the Macy Foundation to fund student projects. This offer was made to the students attending a Macy Conference on the radical student movement's influence on medical schools. The students were to design a project and request the financial aid from the Foundation.

This is indeed what transpired and in the summer of 1969 an urban and rural project was carried out by the resulting Student Health Coalition. The Coalition had as its principle investigators Dr. Amos Christie, of Vanderbilt, and Dr. Leslie Falk, of Meharry. These two initial endeavors were designed as a means of becoming acquainted with the rural and urban health care problems upon which a more realistic project could be devised for the following summer.

It was felt that with this joint participation by Vanderbilt and Meharry students a viable organization for further work in the area of health care might become a reality.

The concept of a joint Vanderbilt-Meharry student project arose from meetings of several medical students from both schools in the Spring of 1970. The student group decided to work within the existing health agencies of Davidson County. Meetings were held with the Metropolitan Public Health Department, Tennessee Welfare Department and Metropolitan Action Committee to acquaint

the group with each agency's services and to explore possible student health projects. The student group realized its limitations which included: The project probably would be short term; supervision by physicians would be a necessity; patients would need a system of scheduling and transportation; for an effective follow-up system financial resources must be available.

A project involving children in foster care homes and applicants for welfare disability was structured within the above criterion by the students. A grant proposal was submitted in April to the Macy Foundation and was approved in May. The group recruited new members to increase its number to nine, who were: Ed Anderson, Clyde Heflin, Joe Holliday, Bill Watson, first year students of Vanderbilt; Frank Stevens, second year student of Vanderbilt; Sandra Bates, James Collier, second year students of Meharry; Brol Quintal and Marjorie Scott, third year students of Meharry. With the assistance of Mrs. Poutch, of Vanderbilt Volunteers, and Mrs. Galloway, of Mathew Walker Health Center, four high school or college girls were obtained as clerks and aids. An abbreviated physical diagnosis program was constructed for the first year students. Third and fourth year students, as well as faculty members, instructed the first year students during the first week in June. The first year students administered approximately eight physical exams to both pediatric and adult patients of Vanderbilt and Veterans Hospitals. Instruction in

obstetrical and gynecological physicals was given at Nashville General Hospital. First year students were taught immunization procedures by the Department of Preventive Medicine at Vanderbilt. At the end of the second week, medical students, working in pairs, examined approximately one hundred and fifty underprivileged children who were departing for camp. During early June, equipment for the summer health project's clinic was either purchased or borrowed.

This paper is a short summary of the second joint student project between the two schools. Project time was divided between applicants for welfare disability and children in the Foster Care Program.

Welfare Disability Applicant Program

We as a group decided from the beginning of the project that we must establish certain goals which we hoped would be helpful to the welfare applicants, to personnel in the Welfare Department, and to us as medical students. As a result we compiled the following list of goals:

1. That our project for the summer should be a joint Meharry-Vanderbilt one.
2. That we should compile a list of suggestions during the project which possibly might improve the system of providing physical examinations for disability applicants.
3. That we should show concern and feeling for the patients to reassure them that we are interested in their problems.

4. That we endeavor to seek out the available medical resources that can be used by the disability applicants and to give this information to the examining physician who could then pass it on to his patient.
5. That medical students use this project as a source of clinical experience and training.
6. That we assure applicants of our help and assistance in getting on the welfare program.
7. That a system of referral and follow-up be established to insure the best evaluation of the patient's condition.

Our summer group consisted of 9 medical students, 4 clinic workers, and 4 volunteer workers, of which one was a public health nurse. Facilities for physicals and laboratory work were made available at Meharry Medical College and the well-baby clinic at Bethlehem Community Center. Arrangements were made by the Tennessee Department of Public Welfare to examine a maximum of twenty applicants twice a week. Three examination rooms and a laboratory were operated at each center once a week. Two medical students were assigned to each examining room and three to the laboratory. Volunteer workers obtained the vital statistics and administered a visual acuity test on each applicant. A rotation schedule was arranged for the medical students so that each student would have the opportunity to work with each other in the examining rooms and in the laboratory. Laboratory work consisted of urinalyses and venipuncture for VDRL. Tuberculin skin tests were administered where indicated. Those receiving the skin test were advised to

return to our clinic or to the Lentz Health Center after 48 hours for interpretation of the reaction. Applicants found to be in need of medical attention were referred to medical facilities which are available to the indigent.

Our program undertook the examination of 92 applicants for disability insurance. These applicants are not eligible for any public health assistance until they have been judged medically disabled and placed on welfare. At this time they become eligible for Medicaid. There are various overlapping programs designed to aid those whose applications are being processed or have been refused, but none are adequate. In many cases patients are being seen by several health agencies concurrently for the same problems, with no communication between the agencies. Patient ages ran from 23 to 69 with the vast majority falling in the 50-60 age range.

Of the 92, 50 were male, 42 were female; 57 were white, 35 were black.

A composition of the medical problems of the applicants compared sex, complaints presented, and physical findings of the examiner. Medical problems were categorized as ophthalmological; ear, nose, throat; respiratory; cardiovascular; gastrointestinal; genitourinary; endocrine; neurological; orthopoedic; and psychiatric.

The tabulations represent independent complaints and findings. "Findings" do not necessarily reflect a percentage of "complaints" in which confirmatory findings occurred, or vice versa. That is, in a given system the "complaints" may represent an entirely different group of people from the "findings," or they may be overlapped in any manner.

MEDICAL FINDINGS ACCORDING TO GENERAL CATEGORIES

SEX	OPHTH.		E.N.T.		RESP.		C.V.		G.I.		G.U.		ENDO.		NEURO.		ORTHO.		PSYCH.	
	C	F	C	F	C	F	C	F	C	F	C	F	C	F	C	F	C	F	C	F
Male	27	11	13	9	32	18	24	25	25	12	7	4	7	3	17	15	23	14	4	3
Female	21	8	10	13	24	10	24	22	24	10	9	8	7	4	22	12	20	10	11	4

C = complaints

F = findings

Total number of males examined = 50
Total number of females examined = 42

At the invitation of Mrs. Freeman McConnell the students examined about thirty Foster Grandmothers at the Senior Citizens Center.

We hope our recommendations will make the system more efficient and more beneficial to the patient. We realize that a few of our suggestions are obvious and somewhat general, but we feel that they need to be made or reiterated. Our recommendations are compiled in the following list:

1. That immediate medical attention be given to the patients when necessary, possibly through arrangement with Social Service at the Nashville General Hospital.
2. That it not be necessary in all cases for the applicant to use the Welfare Department physician as his medical evaluator so that he can use instead his present medical facility to fill out the M-50 form. In many cases this would be a clinic such as Meharry Outpatient Department, Mathew Walker Center or the Nashville General Hospital.
3. That personal contact be used to obtain the medical records of applicants if they are available, and that the medical examiner be provided with the records if they are at nearby facilities and will prove helpful in assisting the patient's condition or disability.
4. That a chest x-ray be made a routine part of the physical examination.
5. That when appointments are made at the Welfare Department, an enclosed self-addressed stamped postcard also be provided to the patient. On the postcard should be indicated

whether or not the patient can meet the appointment and whether or not he can provide his own transportation.

6. That whenever the patient is not totally and/or permanently disabled, and if the disability can be removed, by treatment, he be referred to the appropriate medical facility and strongly urged to keep his appointment.

7. That an effort be made to continue the program with the use of medical students in following summers and perhaps throughout the school year as a part of the elective curriculum.

8. That the M-50 form be made more comprehensive and detailed in an effort to provide much needed information.

9. That the time required to process applications be shortened if possible.

10. We recommend that the following list of resources available to the indigent be sent to the physicians who give the M-50 physicals, and that the physicians be requested to make use of them when possible. We also suggest the physicians be requested to notify the Public Health Department in cases where a referral is made and to ask that a public health nurse be assigned the task of getting him to his appointment.

Vocational and Medical Resources for the Indigent in Metropolitan Nashville.

Employment and Medical Care Program

Drug Program for the Indigent - 291-5100
Key Person - Joseph M. Bistowish, M.D.

Through 80 pharmacies under contract to the Metropolitan Health Department, free medicines are dispersed to indigent persons who are not eligible for free medicines from other sources. Prescriptions may be written by a physician. The Metropolitan Welfare Commission certifies eligibility according to its indigency scale.

Concentrated Employment Program - 741-4179
1120 4th Avenue North, Nashville 37208
Director - Leroy Drakes

The Nashville C.E.P. provides for program enrollees' basic education, work orientation, work experience, counseling, testing, guidance, on-the-job skill training, medical care, transportation, day care services for enrollee's children, and a variety of other supportive services that make it possible for them to find and keep jobs. C.E.P. is designed to provide jobs, work experience, and training opportunities for the "hard core" unemployed and under-employed in a specific "target area" in Nashville, the Model Cities area of North Nashville. Supported by the Federal Government and contributions. Age group served 18 and older. Capacity 1000. Office hours 8 to 4:30, Monday through Friday.

On-the-Job Training Program - 747-4671
c/o Metro Action Commission
315 Third Avenue North
Director - Frank Bailey

Provides a minimum of four weeks and a maximum of 20 weeks on-the-job training with an employer who will pay at least the minimum wage and furnish permanent, full-time employment to the trainee upon completion of training. Minimum age 18.

Big Brothers of Nashville 242-3674
Stahlman Building 37201
Executive Secretary - Mrs. Charles Corwin

Can provide emergency medical care to adults or children if no other resource is available.

Division of Vocational Rehabilitation 741-2521
1808 West End Avenue, Nashville 37203
Assistant Commissioner - D. E. Reece.

The Division offers services to handicapped people who are unable to work because of disability. All the services offered are designed to help the handicapped person get into productive employment.

Health Care Facilities

Middle Tennessee Chest Disease Hospital
Ben Allen Road, Nashville 37216 262-4571
Medical Director - W. W. Hubbard, M.D.

A State-operated hospital for the treatment of all forms of chronic pulmonary diseases with special emphasis on tuberculosis. There is no cost for medically-indigent patients. Applications for admission are made through the local health department.

Metro General Hospital and Metro Bordeaux Hospital
(See attached indigency scale)

Mathew Walker Health Center

Free medical services for persons living in the target area. Includes dental care.
(See enclosed map)

Dental Division of Metro Health Department 291-5100

Free dental care for indigent patients

Meharry Multi-Test Screening Center
Director - Frank Perry, M.D. 254-6572

Non-acutely ill adults referred by their physicians will have an appointment made for a 3-hour series of 27 blood, urine, ECG, spirometric, x-rays, dental, visual, audiometric and medical history tests with rapid return of results to the referring physician for evaluation. No fee for medically indigent patients.

INCOME SCALE FOR DETERMINING MEDICAL INDIGENCY

METROPOLITAN GOVERNMENT
Revised July 1, 1969

Maximum Monthly Income	Number in the family (all dependents included)										Maximum Annual Income
	1	2	3	4	5	6	7	8	9	10	
$190.	I										$2280.
220.		I									2640.
250.	II		I								3000.
280.		II		I							3360.
310.	III		II		I						3720.
340.		III		II		I					4080.
370.			III		II		I				4440.
400.				III		II		I			4800.
430.					III		II		I		5160.
460.						III		II		I	5520.
490.							III		II		5880.
520.								III		II	6240.
550.									III		6600.
580.										III	6960.
610.										50%	

NOTE: Add $360.00 per year income for each dependent in excess of 10.
Families falling within the next income bracket will be granted a 50% discount on their bill.

Scale I - Clinic
II - Hospital Admission
III - Long term illness (cancer) more than 10 days

PHNa-56-69
(Adopted by Board of Health 12-17-69)

STREET ADDRESS GUIDE
SERVICE AREA OF THE MATTHEW WALKER HEALTH CENTER
OF MEHARRY MEDICAL COLLEGE (FEBRUARY 1970).
CITY DIRECTORY 1968

Name of Alley, Avenue, Place or Street	Location	Residential Addresses
Academy	Hermitage - Carroll	14-26 (Even)
Adams	Madison - Van Buren	None
Allison	Ewing - 8th Ave. So.	631-715
Almond	Demonbreun - Middleton	None
Archer	Ridley Blvd. - 12th Ave. So.	671-1117
Argyle	8th Ave. So. - 9th Ave. So.	808-852 (Even)
Arthur	Monroe - Buchanan	1400-1736
Ash	2nd Ave. So. - 6th Ave. So.	309-518
Bass	6th Ave. So. - 8th Ave. So.	614-712B
Beech	Reservoir - Argyle	None
Bertha	Chestnut - Ridley Blvd.	1200-1221
Bethlehem (Prison)	16th Ave. No. - 20th Ave. No.	None
Blank	Herman - Jackson	900-971
Broadway	11th Ave. So. - 15th Ave. So.	1149, 1501½
Buchanan	3rd Ave. No. - 18th Ave. No.	303-1604
Buck's	Demonbreun - Lea	523
Burk's	Charlotte - Pearl	402-412
Burns	Van Buren - RR Spur	None
Cannon	Wharf Ave. - E. to Lewis	None
Carroll	3rd Ave. So. - Wharf	2-99
Cass	3rd Ave. No. - 15th Ave. No.	302-1407
Cecilia	6th Ave. No. - 15th Ave. No.	1102-1107
Cement Plant Road	Van Buren - Hume	None
Central Street	8th Ave. So. - 9th Ave. So.	807A-826

Name of Alley, Avenue Place or Street	Location	Residential Addresses
Central Street (Alley)		None
Century	16th Ave. No.-17th Ave. No.	1614-1622
Cephas	Buchanan - Clay	1800-1925
Charlotte	I&N RR - 17th Ave. No.	1016-1624
	17th Ave. No.-I&N RR Overpass	1804-2300 (Even)
Cheatham	8th Ave. No.-11th Ave. No.	810-1033
Cherry	Olympic-Chestnut	1105-1122
Chestnut	8th Ave. So.-9th Ave. So.	802-826
Church	11th Ave. No.-15th Ave. No.	1305,1410
	15th Ave. No.-17th Ave. No.	1509-1628
Claiborne	Lafayette - Cannon	None
Clark	6th Ave. So. - 10th Ave. So.	None
Clay	3rd Ave. No.-15th Ave. No.	300-1414
	15th Ave. No.-18th Ave. No.	1501-1605 (Odd)
Clifton	20th Ave. No.-L&N RR	2012-2106
Clinton	11th Ave. No. - 19th Ave. No.	1105-1511A
Cockrill	11th Ave. No. - 15th Ave. No.	1401,1407
	16th Ave. No. - 17th Ave. No.	1603,1605,1607 (Odd)
Coffee	3rd Ave. No. - 11th Ave. No.	503-703
Comers		None
Criddle	Harrison - Dead End	None
De Hart's		None
Delta	8th Ave. No. - Cecilia	1500-2009
Demonbreun	1st Ave. So. - 19th Ave. So.	603-1533
Desha	9th Ave. No. - Fisk	None
Division	8th Ave. So. - 12th Ave. So.	805-1037½
	12th Ave. So. - 16th Ave. So.	1102-1524

Place or Street	Location	Residential Addresses
Drexel	7th Ave. So. - 8th Ave. So.	707, 709
Edgehill	9th Ave. So. - 12th Ave. So.	909-1101
	12th Ave. So. - 14th Ave. So.	1201-1315 (Odd)
Elliott	Summit South	None
Elm	2nd Ave. So. - 5th Ave. So.	None
Ewing	Lea Avenue - Bass	612-933
Fall	Ridley Blvd. - Chestnut	1103-1114
Felicia	Clifton Ave. - 24th Ave. No.	None
Ferris	Lea Avenue - Mulberry	629-711
Fisk	Charlotte Ave. - Herman	405-516
Fogg	Ewing Ave. - 8th Ave. So.	631-646
Franklin	1st Ave. So. - 6th Ave. So.	None
Garfield	2nd Ave. No. - 11th Ave. No.	406-1023
Gay	L&N Overpass - 12th Ave. No.	1028-1125
Gleaves	8th Ave. So. - 11th Ave. So.	829-911
Goff	Delta - 9th Ave. No.	825-834
Grand	Overton - 12th Ave. So.	1007A-1045
Grundy Court	L&N RR - 12th Ave. No.	None
Gurndy Street	L&N RR - 15th Avenue No.	1407
Harrison	3rd Ave. No. - 16th Ave. No.	None
Hawkins	9th Ave. So. - 12th Ave. So.	901-1111
Heiman	11th Ave. No. - 16th Ave. No.	1203-1412
Henry	16th Ave. No. in John Henry Hale	1600-1635A
Herman	5th Ave. No. - 18th Ave. No.	1004A-1737
Hermitage	Peabody - Lindsley	35-95
Hermosa		None
Horton	9th Ave. So. - 12th Ave. So.	901-1010
	12th Ave. So. - 14th Ave. So.	1200-1314 (Even)
Hubbs	16th Ave. No. - 20th Ave. No.	None

Place or Street	Location	Residential Addresses
Hume	1st Ave. No. - 8th Ave. No.	310-614
Hynes	11th Ave. No. - McMillan	1300-1415
Ireland	9th Ave. No. - 16th Ave. No.	904-1452A
Jackson Court	4th Ave. No. - 5th Ave. No.	411-420
Jackson Street	1st Ave. No. - 12th Ave. No.	901-1120
	12th Ave. No. 18th Ave. No.	1207-1629A (Odd)
Jane	Delta - 11th Ave. No.	829,830
Jefferson	1st Ave. No. - 12th Ave. No.	309-1119
	12th Ave. No. - 16th Ave. No.	1204-1406 NS (Even)
Jenkins (Alley)		None
Jo Johnston	L&N RR Overpass - 21st Ave. No.	1015-2019
Keegan		None
Kellow	9th Ave. No. - 11th Ave. No.	1019-1024
Key's		None
Koscis	Grand - Horton	None
Kuhn	University - Academy Place	None
Lafayette	West of 2nd Ave. So. (Housing Project)	78-141 Unknown
Laura Lane (Alley)		None
Laurel	11th Ave. So. - Division	1119-1528
Lea	Hermitage - 10th Ave. So.	25-714A
Lee's		None
Liberty	Bluff - Peabody	None
Lime		None
Lindsley	3rd Ave. So. - 1 block beyond Hermitage	15-202
Locklayer	9th Ave. No. - 10th Ave. No.	900-938
Lyle	Charlotte - Jo Johnston	403-416
McMillan	Church - beyond Charlotte	205-327

Name of Alley, Avenue Place or Street	Location	Residential Addresses
Madison	1st Ave. No. - 11th Ave. No.	409-1027
Magazine	Gleaves - Division	607, 607½
Mansion	Overton - Magazine	None
Mary	Cheatham - Garfield	1501-1522
McGavock	1st Ave. So. - 10th Ave. So.	513-811
	11th Ave. So. - 16th Ave. So.	1126-1501
Meharry	11th Ave. No. - 12th Ave. No.	1104-1116
Merritt	L&N RR - Ridley Blvd.	731
Merry	21st Ave. No. - L&N RR	None
Middleton	2nd Ave. No. - Hermitage	28-42
Nilson	11th Ave. No. - 18th Ave. No.	1106-1506
Monroe	Adams - 11th Ave. No.	204-1037
Morrison	Herman - Meharry Blvd.	900-1021
Mulberry	3rd Ave. So. - Ewing	611½, 613
Mulloy	16th Ave. No. - 19th Ave. No.	1708½-1714
Nassau	Garfield - Coffee	1701-1827
New Carroll		None
North	3rd Ave. No. - 4th Ave. No.	301,313
Olympic	Ridley Blvd. - 12th Ave. So.	705-817
Overton	Gleaves - Edgehill	703-1025½
Owen	Clay - Buena Vista Pike	1801-2129
Patterson	16th Ave. No. - 17th Ave. No.	1604-1643
Peabody	Cumberland River-6th Ave. So.	98,98½,313,317
Pearl	L&N RR - 13th Ave. No.	1020-1205
Phillips	9th Ave. No. - Warren	905½-1008
Pickett		None
Pine	12th Ave. So. - Division	1208-1312
Prison Alley (Bethlehem Alley)	16th Ave. No. - 20th Ave. No.	None

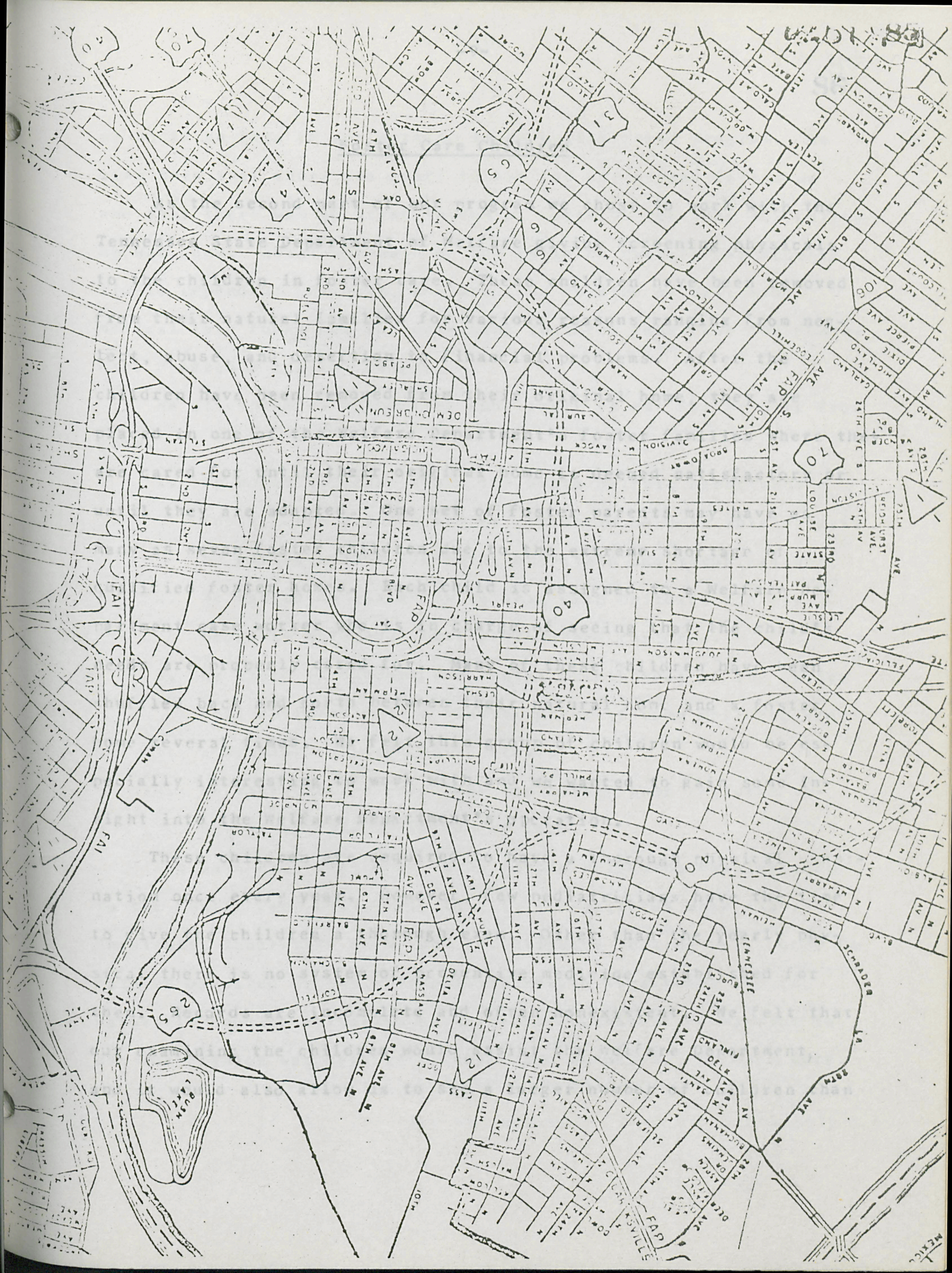
Name of Alley, Avenue, Place or Street | Location | Residential Addresses

Reid	Ridley Blvd. - 8th Ave. So.	668-764
Reservoir	9th Ave. So. - 11th Ave. So.	905-1005B
Ridley	Bass - Chestnut	800-1113
Rutledge	Peabody - Middleton	16-45
Scovel	9th Ave. No. - 16th Ave. No.	908-1415B
Shankland	10th Ave. No. - 16th Ave. No.	None
Shirley	6th Ave. So. - 8th Ave. So.	703-715½
Sigler Alley	9th Ave. So. - Overton	None
Sigler Street	Overton - 12th Ave. So.	995-1020B
Sneed's		None
South	8th Ave. So. - Overton	809-1124
Sparkman	Under Shelby Bridge	None
State	McMillan - 17th Ave. No.	1603½-1632
Stevens	8th Ave. So. - 12th Ave. So.	804-1107
Summit	9th Ave. So. - 12th Ave. So.	1001-1111
Taylor	Adams - 9th Ave. No.	303-830
Townsend	16th Ave. No. - Jo Johnston	500-578
Underwood	14th Ave. No. - 16th Ave. No.	1401-1510
University Court	Carroll - Carroll	1-187
University Street	Middleton - Wharf	3[illegible]-37
Van Buren	Burns - 5th Ave. No.	300-316
Vernon	8th Ave. So. - 11th Ave. So.	807-1015C
Vine		None
Warner	19th Ave. No. - 20th Ave. No.	1915-1927
Warren	Herman - Jefferson	901-1035
Webmore	Ewing Ave. - 8th Ave. So.	626-714
Wharf	Lafayette - Carroll	72-142
Wheless	11th Ave. No. - 17th Ave. No.	1112-1611

Street	Location	Residential Addresses
Whiteside	1st Ave. No. - 3rd Ave. No.	None
Woods Alley	16th Ave. No. - 17th Ave. No.	None
Woods Street	Ewing - Overton	600-904
1st Avenue, North	L&N RR Overpass-Hume Street	700-1201
1st Avenue, South	McGavock - Peabody	421
	Lindsley-Lafayette, Sudekum Homes	901-920A
2nd Avenue, North	L&N RR - Jefferson	202,203,205,1003
	Jefferson - Bush Lake	1204-1414
2nd Avenue, South	Shelby Ave. Bridge-Lafayette	143-906
3rd Avenue, North	L&N RR - Bush Lake Road	1121-2014
3rd Avenue, South	McGavock - Carroll	303-813
4th Avenue, North	L&N RR Overpass- Bush Lake Rd.	815-2008
4th Avenue, South	McGavock - Mulberry	318-838
5th Avenue, North	L&N RR Overpass - Cass	800-2011
5th Avenue, South	McGavock - Mulberry	215-819
6th Avenue, North	L&N RR Overpass - Cecilia	1004-2125
6th Avenue, South	McGavock - Mulberry	129-826
7th Avenue, North	L&N RR Overpass - Clay	1104-1818
7th Avenue, South	McGavock - Archer	102-926
8th Avenue, North	L&N RR Overpass - Cecilia	1001-1827
8th Avenue, South	McGavock - Chestnut	137-1127
	Chestnut - Argyle	1301-1707 (Odd)
9th Avenue, North	Harrison - Cumberland River	918-2114B
9th Avenue, South	McGavock - Summit	125-1413B
	Summit - Argyle	1600-1617
9th Court South	Woods - Vernon	812A-1212B
10th Avenue, North	Pearl - Cumberland River	901-2023

Name of Alley, Avenue, Place or Street	Location	Residential Addresses
15th Avenue, South	Broadway - Laurel	124, 128
16th Avenue, North	Charlotte - Jackson	405-962½
	Jefferson - Cockrill	1100-1528
	Cockrill - Clay	1600-1930
16th Avenue, South	McGavock-Division ES	None
17th Avenue, North	Church - Charlotte	216, 304½, 304B (Even
	Charlotte - Jackson	400-929
	Cockrill - 18th Avenue, No.	1600-1746 (Even)
18th Avenue, North	Charlotte - Herman	402-819
	Buchanan - Clay	1800-1912 (Even)
19th Avenue, North	Charlotte - L&N RR	401-605
	L&N RR - Hermosa (Even)	810, 816, 816½, 826, 828
20th Avenue, North	Clifton - L&N RR	503-515
21st Avenue, North	Charlotte - L&N RR	400-512½
22nd Avenue, North	Charlotte - Clifton	402
23rd Avenue, North	Charlotte - L&N RR	None

Name of Alley, Avenue, Place or Street	Location	Residential Addresses
10th Avenue, South	McGavock - Summit	212-1312
11th Avenue, North	Grundy - Charlotte WS	None
	Charlotte - Jefferson	413-1030
	Jefferson - Cockrill	1101-1543 (Odd)
	Cockrill - Buchanan	1601-1723
	Buchanan - Clay ES	1810-1930 (Even)
	Clay - Cecilia	2101-2135
	Kellow - Jennings	2300-2320 (Even)
11th Avenue, South	Broadway - Gleaves WS	None
	Stevens - Archer	806A-1011
	Edgehill - Summit	1201-1271
11th Court North BS		None
12th Avenue, North	Keegans Alley - Jackson	147-938
	Jefferson - Cecilia	1407B-2142
12th Avenue, South	Broadway - Division	609
	Division - Edgehill ES	704-1028 (Even)
	Edgehill - Horton	1200-1377
	Horton - Summit	1400 (Even)
13th Avenue, North	Broadway - Jo Johnston	121-579A
13th Court South	Edgehill Project	None
14th Avenue, North	Grundy - Charlotte	124-322
	Jo Johnston - Jackson	601-967
	Jefferson - Cecilia	1104-2137
15th Avenue, North	Broadway - Church	None
	Church - Charlotte	216-321
	Charlotte - Clinton	402-611
	Buchanan - Clay	1801-1921
	Clay - Cecilia	2006-2138 (Even)



Foster Care Children

As the second part of our program we chose to work with the Tennessee State Department of Welfare giving screening physicals to the children in foster care. These children have been removed from their natural families for various reasons ranging from neglect, abuse, and desertion to financial problems. After the children have been removed from their original home, they are placed in one of the Welfare Department's foster families where they are cared for until their original home is deemed satisfactory or until they are adopted. One set of foster parents may have as many as seven foster children due to the extreme shortage of qualified foster homes. Each child is assigned to a Welfare Department case worker who is in charge of seeing that the child's needs are properly cared for. Many of these children have been shuffled back and forth between their natural home and a foster home several times. We felt this group of children would be especially interesting to work with and we wanted to gain some insight into the Welfare Department's operation.

These children are required to have a thorough physical examination once every year. However, few pediatricians have the time to give the children a thorough exam. Other than the yearly physical there is no system of preventive medicine established for them. Records are incomplete and often nonexistent. We felt that our examining the children would assist the Welfare Department, and it would also allow us to see a larger number of children than

we would be able to see working in an unstructured program. We also knew that there was money to pay for any needed follow-up and that there was an organization of sorts to see that the follow-up was done. About one-half of the children qualify for Federal Aid to Dependent Children, and are thus covered by Medicaid. Medical care funds for the remaining children come from the Foster Care Program's limited budget.

We attempted to accomplish four goals in our Foster Care Program.

1. We hoped to learn about the State Welfare Department's Foster Care Program and we attempted to help this program by giving needed screening physicals and immunizations.
2. We wanted to learn how to deal with children and especially with emotionally disturbed children.
3. We hoped to compare the mental development of the foster home children with a control group of camp children from a similar socio-economic class.
4. We wanted to be sure that the foster home children received any needed follow-up care.

Two days each week were spent giving screening examinations to the Foster Care Children. In all, 194 children were examined. Physicals, laboratory work, and intelligence testing were done in clinics operated by the Metropolitan Health Department and the Nashville Housing Authority as well-baby clinics. Permission to use the clinics was granted by these two agencies. Clinics were

scheduled at three different locations during the summer in order to minimize the problem of patient transportation. Transporation for the children was provided by Welfare Department workers.

A definite procedure was followed after the child arrived at the clinic. A verbal skill-based IQ test (Peabody Picture Vocabulary Test) was given to the child first. His sight, weight and temperature were then checked by a clinic worker. The physical was then given by the students. Three examining tables were operated at one time with two students at each table. Required immunizations were given on completion of the physical. Immunization materials were donated by the Metropolitan Health Department. Polio, smallpox, rubella, DPT, DT and tetanus immunizations were available. Finally, blood work and urinalysis were done for the patient by two students working in the laboratory. The urinalysis checked for blood, sugar, pH, protein and ketones in the urine. The hematocrit was measured on the blood sample and the hemoglobin content was derived from this. A licensed physician was always present for consultation and supervision.

Duplicates of the physical forms filled out by the examiners were made and put in our files. Copies of the immunization forms were made out for the Metropolitan Health Department and the Welfare Department. Children needing further health care were brought to the attention of the Welfare Department case workers who then took the children to pediatricians or other specialists.

Several striking facts present themselves on examination of our records. Of the 194 children examined, 92 or 47% had significant

MEDICAL FINDINGS ACCORDING TO GENERAL CATEGORIES

Children			Classification*	Medical Findings																	
Sex + Race	Normal	With Med. Findings		Heart	Ear	Abdominal Mass	Ophthamology	Hearing & Speech	Respiratory	Dermatology	Signs of Abuse	Hernia	Gynecology	Dental	Orthopedic	Neurological	Mental Retard.	Psychological	Anemia	TB	Testicular non-descent
Female Black	21	21	1	2	4	0	2	2	2	1	0	0	0	0	2	2	1	0	2	0	X
			2	0	1	0	1	0	0	0	0	0	1	2	1	0	0	2	2	0	X
			3	1	4	0	2	2	2	1	X	0	1	2	0	1	0	2	0	0	X
Female White	25	14	1	0	3	1	1	0	0	0	1	0	0	0	1	0	0	1	4	0	X
			2	0	0	0	0	0	0	0	0	0	0	0	0	1	1	1	4	0	X
			3	0	2	1	1	0	0	0	X	0	0	0	0	0	0	1	0	0	X
Male Black	21	30	1	3	1	1	1	0	4	6	1	5u	X	2	2	1	0	3	2	2	0
			2	0	0	0	0	0	0	1	0	1u+I 1ú	X	0	0	0	1	0	0	0	0
			3	0	0	0	0	0	2	0	X	1	X	2	1	1	0	2	1	2	0
Male White	35	27	1	5	5	1	3	1	3	7	0	1 I	X	4	1	0	0	2	0	0	2
			2	0	0	0	0	0	0	0	0	0	X	0	1	2	3	0	0	0	0
			3	3	3	1	3	1	2	1	X	1	X	3	1	0	0	2	0	0	2

*Classification:
1 = occurring singularly
2 = occurring with other findings
3 = needing immediate follow-up (includes 1 and 2)

(1) Heart - if follow-up not needed indicates functional murmur
(2) Respiratory - URI's were not included
(3) Hernia - u = umbilical I = inguinal
(4) Anemia - 1-3 yr. 11.2 hemaglobin
3 yrs & older 12.0 hemaglobin
(5) Testicular non-descent - age above 3

medical findings. Ten percent of those with significant findings were referred to ENT clinics. Four children had organic heart problems which had not been followed up previously. Approximately 75% of the children examined needed some type of immunization. In general, both oral hygiene and personal hygiene were poor. The number of mental and emotional problems appeared to us to be very high.

The Peabody Picture Vocabulary Test was used to measure the I.Q. of the children examined. The test was delivered by elementary school teachers. The test was given to children between the ages of 5 and 18. We were interested in determining three things from the test: 1) Whether or not this particular test was an adequate, non-time-consuming intelligence test for children in the lower socioeconomic groups, 2) if there was a difference in the average I.Q. of a group of children from low income families and the foster care children, and 3) if that difference was significant. The control group was composed of children who received physicals from our group to allow them to go to camp. These children were considered to be from lower income families.

The test takes only five to ten minutes to perform, but the scores are based entirely on the subject's ability to associate vocabulary words with pictures. Many tests could not be used in the calculations because the raw scores were below the lowest raw scores for which the authors had calculated an I.Q. (55). This occurred 28 times in the Foster Children group and 7 times in the

control group. The results for those tests which were valid are given below.

	Number	Mean	St.Dev.
Control	127	83.40	14.68
Foster Children	116	82.08	13.37

Because of the large number of tests which could not be used in the calculations because of low scores (i.e. I.Q. below 55), a statistical comparison between the two groups would be irrelevant. What is significant is that 19% of the foster children had scores below 55, while only 5% of the camp children scored below that level. This points to a problem among foster care children which needs more attention. However, the calculated results do point to the fact that the test was designed for middle class children and is not a good measure of I.Q. in the group of children we were working with.

After a summer's involvement in the Foster Child Program, we have made three general observations. First, these children need better medical care. Continuity of medical care for these children needs to be emphasized and made a reality. Also, immunization and other medical records are generally grossly inadequate. Thirdly, these children suffer greatly from repeated displacement and replacement out of and into various homes. To increase the available medical care we suggest that:

1. All Medicaid children be taken to the Vanderbilt Pediatric Clinic as private patients.
2. More pediatricians in private practice be encouraged to

participate in the Foster Care Program. Foster care children living in outlying areas of Davidson County such as Donelson and Madison would benefit from care by a local pediatrician.

3. In the future, a pediatric nurse practitioner, employed by the State Welfare Department under the supervision of a practicing physician could deliver most of the pediatrician's routine care.
4. The State Welfare Department consider hiring a child psychiatrist, or more realistically a clinical psychologist. Even though a majority of the children in foster care have mental and emotional problems, few have received psychiatric consultation. Shortage of this type of medical care receives our strongest criticism of the Foster Care Program.

We have three recommendations which might help alleviate the problem of deficient records for people delivering health care to these children in the future.

1. The entire Welfare Department record should be made available to the examining physician since the past history cannot be obtained from the child or the Welfare worker. Of particular interest to the physician would be the typewritten resume kept on each child.
2. Forms for an improved system of follow-up are needed. We suggest that the form include (a) the name of the clinic

or physician to whom the child is being referred, (b) the maximum amount of time the child can go without seeing a physician, i.e. whether he needs immediate attention or can wait for a regular appointment, and (c) the signatures of the physician who performs the follow-up and the Welfare worker once the follow-up has been finished. The referring physician should send one form directly to the Welfare Department and give one form to the worker. In this manner the Welfare Department could check weekly on the number of children who have had the needed follow-up.

3. A better system is needed for follow-up on immunizations to assure completion of a series started by the physician performing the annual physical or to assure the receipt of the immunizations that could not be administered at that time. In this way completed series would not be restarted and incomplete series could be finished.

To decrease the number of traumatic experiences a child must undergo as a result of repeated movement from home to home, we recommend that:

1. The judiciary system should place the welfare of the child before that of the parents. Continual movement from natural home to foster home and back produces great uncertainty within a child. Repeated exposure to an alcoholic or abusing parent often creates an emotionally disturbed child whose final destination will be Central State Psychiatric Hospital.

2. Through an increased budget and local publicity, the Welfare Department should increase the number of well qualified foster care parents.

We express our thanks to Dr. Amos Christie who unselfishly gave us endless hours of advice and guidance. We are endebted to Miss Watson, Dr. Fleming and Dr. Bistowish, of the Metropolitan Public Health Department, Mr. Bailey, of the Bethlehem Center, Dr. Johnson and Dr. Anderson, of Meharry Medical College, and the Nashville Housing Authority for the use of their facilities. We are appreciative of assistance given us by Mrs. Dunaway, of Vanderbilt Medical School, Mrs. Oliver and Miss O'Neal, of the Tennessee State Welfare Department, and Dr. Falk, of Mathew Walker Health Center and Meharry Medical College.

MACY FOUNDATION PROJECT PARTICIPANTS

Participants	Medical School	Year Completed Thus Far
Anderson, Ed	Vanderbilt	First Year
Bates, Sandra A.	Meharry	Second Year
Collier, James R.	Meharry	Second Year
Heflin, Clyde	Vanderbilt	First Year
Holiday, Joe	Vanderbilt	First Year
Quintal, Errol	Meharry	Third Year
Scott, Margerie	Meharry	Third Year
Stevens, Frank	Vanderbilt	Second Year
Watson, William	Vanderbilt	First Year

CENTER LOCATION SCHEDULE

Date	Center
Wednesday June 17th	Bethlehem Center
Thursday 18th	Bethlehem Center
Friday 19th	Sam Levy's
Monday 22nd	Bethlehem Center
Wednesday 24th	Bethlehem Center
Thursday 25th	Cumberland View
Friday 26th	Sam Levy's
Monday 29th	Meharry Out-Patient Clinic
Wednesday July 1st	Bethlehem Center
Thursday 2nd	Cumberland View
Friday 3rd	HOLIDAY
Monday 6th	Meharry Out-Patient Clinic
Wednesday 8th	Bethlehem Center
Thursday 9th	Cumberland View
Friday 10th	Meharry Out-Patient Clinic
Wednesday 15th	Bethlehem Center
Thursday 16th	Cumberland View
Friday 17th	Sam Levy's
Monday 20th	Meharry Out-Patient Clinic
Wednesday 22nd	Bethlehem Center
Thursday 23rd	Cumberland View
Friday 24th	Sam Levy (or Gernert)
Monday 27th	Meharry Out-Patient Clinic
Wednesday 29th	Senior Citizens Center
Thursday 30th	Cumberland View
Friday 31st	Gernert

Date		Center
Monday	August 3rd	Meharry Out-Patient Clinic
Wednesday	5th	Senior Citizens Center
Thursday	6th	Cumberland View
Friday	7th	Gernert
Monday	10th	Meharry Out-Patient Clinic
Wednesday	12th	Bethlehem Center
Thursday	13th	OPEN
Friday	14th	Gernert
Monday	17th	Meharry Out-Patient Clinic
Wednesday	19th	Bethlehem Center
Thursday	20th	OPEN
Friday	21st	Gernert

AN EVALUATION OF THE STUDENT HEALTH COALITION'S RURAL HEALTH PROJECT

Celeste Simpkins and James McCorkel, Ph.D.
Peabody College

In the summer of 1970 a team of 37 students, most of them in medicine and in nursing at Vanderbilt University, set up an experimental program of health fairs in several rural counties in Eastern Tennessee. The students' efforts were directed toward sanitation, health screening, and health education.

However beneficial the program was for the residents of these rural counties--and at least one reporter has made a glowing assessment[1]--one of the real benefits should have been to the students themselves. At the least, one would expect that the summer's experience should have led the students to a new appreciation of the problems of delivering health care in poverty--stricken rural communities.

The evaluation herein described is based on changes in the students' responses to a simple questionnaire which they filled out immediately before and after their rural health project. It demonstrates that, on balance, the students became considerable more sophisticated concerning the problems of health care delivery and organization.

How do we arrive at this conclusion? The questionnaire was developed in the Spring of 1969 to assess the extent of sophistication of medical students in the areas of health care organization and community medicine. Most of the questions emerged from brainstorming sessions organized by Dr. James Carter, Department of Pediatrics, Vanderbilt University. Dr. Carter had assembled a group of experts from the Vanderbilt and Meharry Medical College faculties. They served the function of generating more than thirty brief statements with which one might agree or disagree, and then proposed whether agreement, or disagreement, would be indicative of sophistication about the topic at hand.

The initial set of questions was pretested, and items which did not discriminate well were eliminated. We concluded that we had a Liker-type scale which was worthy of further development as an indicator of the extent to which student attitudes and

[1] Samuel Z. Goldhaber, "Appalachia: Two Approaches in Student Summer Health Projects," Science, 1970, 169:746

opinions match the opinions of selected medical experts. Then students' summer experiences, their planned specialties, their social background and year in medical school, and we set out to discover whether attitudes change, and how, over one's career in medical school, or over a summer. Finally, at the suggestion of Dr. Per Stensland, Ph.D., Senior Member of the Technical Staff, of the Milbank Fund, we included two open-ended questions, one on the elements of primary medical care, the other on the number of trained health practitioners in a small city in the U.S.A.

Findings

The students came from family backgrounds which would have prepared them little for rural poverty. All but seven of the thirty-seven students had fathers who worked as professionals of one sort or another (using U.S. Census classifications). Only six of the students' fathers had not attended college; sixteen had attended graduate schools or professional schools; of these, seven were physicians. Both before and after the summer, half of the 20 medical students in the group indicated that they were specializing in internal medicine, surgery, or pediatrics; only four listed community medicine or family medicine as their choice. Fifteen of the students were in their third or fourth year of medical school, five were in their second year, seven were nursing students, and ten were graduate or undergraduate students. Sixteen of the thirty-seven students came from an urban background, either a large city or a suburb of a large city, twelve reported their home town as a small city, the remaining 9 students reported a small or middle size town. Most of the students named a Southern city or town as their home town (22 of the 37). Fourteen named a Northern town and one a city in the midwest.

In September 76% of the 37 students reported that their summer's experience contributed a great deal to their medical education, whereas only 24% reported in June that their previous summer's experience had been so beneficial. All of the students reported that the Rural Health Project had contributed something to their education.

Students were asked to describe, in a paragraph or two, the elements of primary medical care for the first-time in June. Since this was an open ended question, responses were all examined and codes formed to include the most complete list which could be formed from the responses given. The items included to form the scale were:

Availability - of medical facility and medical professionals
Accessability - of the patient to this facility and those professionals
Comprehensive Care - including diagnosis, treatment and preventive care

One point was given for mention of Availability or presence of a medical facility and professionals. One was given for mention of accessability, which included mention of the patients right to medical care and treatment regardless of his ability to pay. The third component of this scale counted up to three points - one each for the mention of diagnosis, treatment and preventive care. These items together amount to a possible score of 5.

In June only two students made mention of all five components of this scale. In September half those responding to the question named all five components.

The most interesting change here however, is not the increased score of the students, but inclusion of new items which do not fit the previous scale at all. There seems to be an increased awareness on the part of the students, that primary medical care is dependent upon the fundamental necessities of life. In the fall we found that more than half the students cited food, clothing, housing, adequate income and environmental factors as elements of primary medical care.

In response to the question of the number of health care professionals in a community of 25,000 people the students in general felt that there were more professionals before their summer experience. More than half (20) the students thought there would be 50 or more professionals in such a community according to the June responses. Seventeen felt there would be 50 or more nurses, three that there would be 50 or more nurses and 50 or more M.D.'s. In September nine students felt that there would be 50 or more nurses, none named fifty M.D.'s. It would seem that the students' perception of availability of medical care is changing downward after their experience with rural poverty communities.

The pretest suggested a rough range of scores for low medium, and high degree of match with our faculty experts. We were interested in the range of scores, the average score and the direction and amount of change in these over the summer. We found that in June 1970, scores for the group ranged from 66 to 142 out of a possible 162 points. After the summer experience the group returned with a low score of 90 and a high of 153 points. Though the highest scoring students gained only 11 points it seems noteworthy that the lowest scoring persons gained at least 24 points after the summer experience.

	June	Sept.
Median Score	113	124
Mean Score	112	123

	June	Sept.
Low 66 - 112	18	6
113 - 127	11	17
High 128-153	8	14

Although the magnitude of change in most individual items and the total scale score was not sufficient to attain statistical significance, the consistent direction of change makes a reasoned interpretation possible.

Attitudes toward financial aspects of medical care, source of fee, amount, etc., displayed interesting changes. No differences were found in the item which stated,

"The kind of medical services which the poor receive should be qualitatively and quantatively as much like those services received by persons able to pay."

More than three fourths of the groups agreed to the statement both before and after their summer experience. In June, however, 62% of the group agreed that "It would be impossible to deliver medical services as above without sacrificing much of the freedom of the physician." After the summer experience 73% disagreed with the same statement, reflecting the students increasing refusal to equate source of payment to freedom of the physician.

Motive for choosing medicine as a career displayed changes in both direction and intensity. In June 53% disagreed with the statement that "Most medical students are going into the medical profession because of financial rewards and prestige rather than the ideals of public service." In September 61% agreed with that statement. Before the summer experience 33% strongly disagreed with this item, after the experience only 7% strongly disagreed.

Agreement that "special economic interests have too often had a negative influence on public health legislation became more intense after the summer experience. Before the summer experience 77% agreed with the statement, following the experience 94% agreed.

Students were made increasingly aware of a need for some type of prepaid health insurance in the United States. Forty-six percent agreed strongly in June that prepaid health insurance programs are fundamental to progressive health planning in the United States. In September the percentage increased to 65%.

Students seemed to become aware of a need for a more comprehensive type medical training after their summer experience in rural poverty communities. In June 75% agreed that more courses in the social and behavioral sciences should be taught in medical school. In September 86% agreed to the statement. More interesting is the change in intensity of agreement. In June 53% strongly agreed whereas in September 71% strongly agreed with the statement.

Fifty-six percent of the group in June did not feel that most physicians are qualified to work with patients who have adjustment or marital problems. A fourteen percent increase in students expressing this opinion was found in the September group (70%).

The nature of the relationship between the patient and his doctor appears increasingly more important as a factor in the patients treatment. In June 49% agreed that this relationship is more important than any other factor, in September 65% agreed to the statement.

The students attitude toward medical professionals and students brought up some interesting changes.

Before and after the experience most students felt that medical assistants could be trained to perform many of the duties of a physician. However, the intensity changed a great deal. In June 72% agreed to the statement, in September 92% agreed.

In June 60% of the students agreed that the public health nurse is the keystone of any preventive health program. In September 50% disagreed strongly with this statement, possibly reflecting unpleasant experiences with existing systems during their summer.

Quite contrary to the above finding was the increased agreement of the supportive roll of the nursing student. In June only 18% agreed that a nursing student working with indigent patients is more likely to play a supportive roll than a medical student, whereas 49% in September.

Name _____ Date _____

STUDENT-PHYSICIAN VALUE STUDY

Medical student, interns, and residents vary considerably in their attitudes toward the medical profession and its role in the community. This questionnaire is designed to make it possible for us to describe selected values and the frequency of their occurance among student physicians with differing preferences for medical specialties.

Section I: Background Information

Age _____ Medical School _____

Sex: M F Year in Medical School _____

of Siblings None 1 2 3 4 5 6 7 8 9+

Race: Black White Oriental Other (Please Specify) _____

Father's Occupation (be specific): _____

Father's Education (Number of school years completed):

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20+

Mother's Occupation (be specific): _____

Mother's Education (Number of school years completed):

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20+

Name of Home Town: _____

What kind of a place is this? (Circle one only)

farm rural small town middle size town

small city large city suburb of a city

Undergraduate academic major: _____

List the two medical specialties you are most likely to choose, in order of preference:

First Choice specialty: _____

Second Choice specialty: _____

Please state how much confidence you have that you will actually end up choosing the specialty you list as the FIRST CHOICE:

_____ I am not at all confident in my choice

_____ I am only slightly confident in my choice

_____ I am moderately confident in my choice

_____ I am quite confident in my choice

Please state how much confidence you have that you will actually end up choosing ONE OF THE TWO SPECIALTIES YOU LIST ABOVE:

_____ I am not at all confident in my choices

_____ I am only slightly confident in my choices

_____ I am moderately confident in my choices

_____ I am quite confident in my choices

Fifty-six percent of the group in June did not feel that most physicians are qualified to work with patients who have adjustment or marital problems. A fourteen percent increase in

Section II: Physician Values and Beliefs

Instructions: The following statements represent a range of views and beliefs about physicians and the practice of medicine. Many of them refer to issues which are a matter of controversy or disagreement. There are no right answers. YOUR OWN CONSIDERED JUDGEMENTS AND VIEWS ARE THE BEST ANSWERS TO THESE ITEMS.

For each of the following statements, indicate frankly to what extent you personally agree or disagree with it. Circle below each statement ONE of the six symbols which BEST represents your own feeling about the statement. Please answer all questions; if in doubt, guess.

AAA = strongly agree
AA = moderately agree
A = slightly agree
DDD = strongly disagree
DD = moderately disagree
D = mildly disagree

1. The kind of medical services which the poor receive should be qualitatively and quantatively as much as possible like those services received by persons able to pay.

AAA AA A D DD DDD

2. It would be impossible to deliver medical services as above (1) without sacrificing much of the freedom of the physician.

AAA AA A D DD DDD

3. The teaching hospital should not concern itself with service to the community.

AAA AA A D DD DDD

4. Men who are paid on a "fee for service" basis turn out better quality service.

AAA AA A D DD DDD

5. Patients in teaching hospitals frequently feel that they are being treated like guinea pigs.

AAA AA A D DD DDD

6. One of the problems of faculty members in medical school is that they want their students to pursue careers in research and teaching rather than in clinical practice.

AAA AA A D DD DDD

7. Most medical students are going into the medical profession because of financial rewards and prestige rather than the ideals of public service.

AAA AA A D DD DDD

8. More courses in the social and behavioral sciences should be taught in medical school.

AAA AA A D DD DDD

9. A psychiatrist is less of a physician than an internist is.

AAA AA A D DD DDD

10. A nursing student working with indigent patients is more likely to play a supportive role than a medical student.

AAA AA A D DD DDD

11. A public health administrator is less of a physician than a surgeon is.

AAA AA A D DD DDD

12. Medical assistants could be trained to perform many of the duties of a physician.

AAA AA A D DD DDD

13. Special economic interests have too often had a negative influence on public health legislation.

AAA AA A D DD DDD

14. The public health nurse is the keystone of any preventive health program.

AAA AA A D DD DDD

15. Prepaid health insurance programs are fundamental to progressive health planning in the United States.

AAA AA A D DD DDD

16. If medical care continues to be unevenly distributed, the result will be socialized medicine.

AAA AA A D DD DDD

17. There are two systems of medical care; an inferior system for the medically indigent, and a superior system for those who can afford to pay.

AAA AA A D DD DDD

18. The physician should be actively concerned with his clinical practice and not with social change in his community.

AAA AA A D DD DDD

19. The management of chronic diseases is adequate in the best medical centers.

AAA AA A D DD DDD

20. Salaried physicians give inferior service.

AAA AA A D DD DDD

21. The Government has raised the hopes and expectations of poor people for quality health care, without making substantial changes in the services actually available.

AAA AA A D DD DDD

22. An unemployed alcoholic has just as much right to receive an artificial kidney as the president of a major corporation.

AAA AA A D DD DDD

23. The nature of the relationship between the patient and his doctor IS MORE IMPORTANT THAN ANY OTHER FACTOR in the patient's treatment.

AAA AA A D DD DDD

24. Class and status distinctions which exist outside the doctor's office should be minimized in the medical setting.

AAA AA A D DD DDD

25. Most physicians are paying insufficient attention to the social causes of illness.

AAA AA A D DD DDD

26. Most physicians are qualified to work with patients who have adjustment or marital problems.

AAA AA A D DD DDD

27. A National health insurance program is the best way to insure comprehensive medical services for everyone.

AAA AA A D DD DDD

Section III: Summer Experience

28. Check the item which best describes the work activity you engaged in this past summer.

_____(1) Lab work - Research
_____(2) Public Health or Community Research Experience
_____(3) Community Health Research
_____(4) Hospital Experience
_____(5) Other activity related to Medical Education
Please specify: _____
_____(6) Work not related to Medical Education
Please specify: _____
_____(7) Unemployed

29. How would you evaluate your past summer's experience in terms of your overall medical education?

_____ Did not contribute at all to my medical education
_____ Contributed only slightly to my medical education
_____ Contributed moderately to my medical education
_____ Contributed a considerable amount to my medical education

30. What plans do you have for work this summer?

_____(1) Lab work - Research
_____(2) Public Health or Community Research Experience
_____(3) Community Health Research
_____(4) Hospital Experience
_____(5) Other activity related to Medical Education
Please specify: _____
_____(6) Work not related to Medical Education
Please specify: _____
_____(7) Unemployed

31. Describe in a paragraph or two: What are the elements of primary medical care?

32. In a typical American community of 20,000 persons, how many of each of the following medical professionals would you expect to find?

_____Internist
_____Pediatrician
_____Ob.-Gyn.
_____Psychiatrist
_____Public Health Physician
_____Public Health Registered Nurses
_____Other Registered Nurses
_____L.P.N.

NOW CHECK TO MAKE SURE YOU HAVE GIVEN ANSWERS TO ALL OF THE ABOVE

32 QUESTIONS

RECOMMENDATIONS FROM THE PROJECT

For the Project

For Orientation

For the University

For the Public Health Department

Miscellaneous

RECOMMENDATIONS FROM THE PROJECT

The following recommendations are the product of group discussions and written reports from participants in the project. Those pertaining to the past summer's work are being incorporated into plans for next summer. Those pertaining to the University, Public Health Department, etc., will be actively pursued during the coming school year by various student segments.

For the Project

Future Projects

At a joint project meeting on August 28, 1970, at the close of the summer rural project's activities, discussion centered around evaluating the summer's work and designating problem areas that may be revised in coming projects. These suggestions, together with suggestions from the personal project reports and evaluations, are summarized here.

Due to lack of adequate medical knowledge, follow-up workers were in need of constant medical supervision during the summer. Follow-up next year in each area should be headed by a medical student or a nurse.

More importance should be given to community organizing in each area, as this aspect of the program lends most to long-range progress in areas of health for the communities.

Lest staff be trapped in boring jobs or lack a well-rounded concept of both the project and the area in which the project travels, the staff should rotate on and off the mobile unit, spending some of the summer living in communities.

A more detailed and workable program in mental health should be expected by next summer. Workers from this summer spent time understanding the child-rearing practices of the area and should be able to work well within such a definition next summer.

More effort should be given to developing a teaching-and-learning atmosphere within the project. Continued evaluation and self-criticism would produce better medical care.

More dialogue between the follow-up personnel and medical personnel is imperative. The range of life-styles and tensions caused rifts to appear in the esprit-de-corps felt by the group at the onset.

In order that the health fairs can operate at a slower pace--to insure better screening and less fatigue among the staff--it is possible that health fares next year can run in some areas for two weeks instead of one. In this way, follow-up can begin DURING the health fair, as records are returned within one week. It is also possible that, under this plan medical personnel could follow their own patients--i.e. the ones they examined--and thus have a more well-rounded view of medical care. Finally, the medical personnel could then live in a community for some length of time and be able to get to know the mountain culture.

In terms of community organization, the health fairs often served as stimuli for community participation and furtherance of organizational skills among local groups. Some local groups are beyond the point, now, of needing a health fair for such a purpose (i.e. the groups with their own clinics). Thus, it is possible that the project will want to reevaluate its goals in terms of the health fairs, sending fairs into communities in need of such a catalyst and sending other personnel into communities which, say, need only a law student or a nurse in a clinic. That is to say, perhaps next year's project could vary its activities more to suit the learned needs of each community which desires its help.

Specific Mechanical Recommendations

These recommendations are in regard to specific mechanical operations of follow-up procedures.

1. Community workers need to know community resources. (See list attached)

2. History sheets need to have included on them name of children's parent or guardian, phone numbers when possible, a more exact description of address when possible.

3. Some basic medical decisions on how vigorously to pursue certain problems should be noted on the history sheet. Policies on what to follow and some suggestions as to how to go about this should be set before the work begins.

4. A community medical secretary is strongly recommended. Perhaps some of our funds could be used where the local council would have trouble doing it.

a. She will be there when we leave.
b. She will know the community and many of the people in it.
c. She can be the nucleus of a clinic. The records she keeps would be valuable starting points.
c. Because she knows the people, she is interested in pursuing their follow-up.

5. Medical write-up recommendations:

a. Physical examiners should do their own histories.
b. Write a formulation in all cases, even those that do not need follow-up.
c. Write an appraisal of the patient's current medical situation: how health-conscious is he? does he have medical insurance or a Medicaid-Medicare card? does he see a doctor regularly?
d. If the patient needs follow-up on the basis of the physical exam, specify what type (see specialist? see nurse on home visit? etc.) and what the patient was told.
e. Have the columns asking when last meal was taken marked immediately prior to drawing blood, so that we have some idea whether we are getting fasting sugars or not.

6. Wherever possible, the physical examiners should write their own formulations. (Per Dr. Christie's advice: "When in doubt, look at the patient.")

7. Each chart need be gone through only once by follow-up workers to begin work. At that time, everything but one lab sheet and one history sheet and the letter are pulled, clerical and/or medical mistakes are checked, and file cars are written out with name, number, doctor, address, and summary of diagnosis.

8. Things go much smoother when the people who are to be doing follow-up decide what kind of letters to write, and make the follow-up decisions on exactly what to do with whom. Hostility arose when a person who was not assuming responsibility tried to make the decisions. We frequently held off sending letters until we decided how to pursue their case.

9. Put on the follow-up card exactly what happens at home visits, record summary of conversations with doctors concerning the patient, and date each entry in order to avoid confusion and wasted time.

10. Home visiting is its own reward. Everyone should get the chance.

Comments from Cooperating Physicians

All visiting and cooperating physicians and nursing personnel who worked with the summer project were asked to submit a summary of their reactions and suggestions to the project. Overall response to the project was quite positive, both in terms of the high quality of medical service rendered and in terms of pleased surprise at the success of an entirely student-run project.

Concern was expressed over two matters, chiefly. One was the limited quality and experience noted in the physical examinations by some physicians. Second was the need for constant professional supervision, which lapsed occasionally during the first two weeks of the project. Comments as to the need for increased sterility in working conditions, more efficient use of the patient's waiting time, less compulsiveness in diagnosing patients (some patients were "overdiagnosed"), and more complete detail notes on patients were also registered. Most of these comments were registered with prior remarks as to the understandable difficulty of conditions where examinations were being conducted.

Some of the favorable comments contradict the foregoing reservations: that is, several physicians noted an admirable quality in the work-ups performed, especially in reference to pediatric examinations performed by nursing students. The efficient use of technologic screening devices on the vans was a source of favorable comment, as was the general bustling good nature of the health fair atmosphere, in spite of long hours. That the local community participated wholeheartedly in the health fair was noted by most visiting physicians, also. Finally, the high degree of organization and enthusiasm among the student personnel of the project was a subject of frequent comment.

Most of the physicians questioned regarded the summer project as a revolution in medical education rather than a startling improvisation in health care delivery. Many favored continued and increased interaction between the University and the project, though the details of such a relationship were not ventured by anyone. Summarily, then, the physicians involved with this summer's work were highly favorable yet honestly critical of the efforts of the Student Health Coalition.

(Note: Copies of the letters of all physicians and nurses are located in Appendix)

Recommendations for Orientation

Rod Lorenz

Orientation Schedule

Monday, June 1

8-10 A.M.	Amphitheater C-2209: Dr. Christie--Opening remarks, everyone should be here; taking a medical history, adult physical exam.
10:30 A.M.	Meeting at Capitol Towers for nurses; complete preliminary testing for those who missed May 28 meeting.
1-2:30 P.M.	T-1306: Dr. Christie--Pediatric physical exam with demonstration
2:30 P.M.	Individual group meetings to discuss goals. Meet wherever you can!

Thursday, June 2

8-10 A.M.	Dr. Christie--Pediatric Ward, Clinical demonstration
9-11:30 A.M.	Law 212, Attorney Harry Huge from Washington, D.C. to speak concerning mine union problems.
10:30 A.M.	Rod Lorenz--Physical diagnosis of head, eyes, ears, nose, throat; lecture; place to be announced.
1-2:30 P.M.	Amphitheater C-2209: Attorney Harry Huge, joint meeting, to speak on federal programs involving Appalachia, mines and unions.
3-4 P.M.	T-1306, Bill Dow--Physical diagnosis of lungs; lecture.

Wednesday, June 3

8-9:30 A.M.	T-1306, Dr. Davidson, physical examination of heart
8:30-10:15 A.M.	Law 212: Professor Karl Warden--Rural practice of law; county structure; conducting a property survey
10:00 A.M.	Individual group meetings in Medical School, wherever you can, to discuss goals.
10:30-12:00	Law 212: Photographer Jack Corn--Short slide presentation; discussion of mountain culture.

1-3 P.M.	Physical diagnosis--Vanderbilt clinics and pediatric wards
3-4 P.M.	Pat Maxwell--Physical examination of abdomen
1:30-3:30	Law 212: Bill Hammett, Community organizer (tentative)

Thursday, June 4

9:00 A.M.	Law 212: Nelson Biddle, Tennessee Planning Commission, author of "Hunger in Tennessee"
9:00 A.M.	T-1306 - Physical diagnosis, clinics and wards
1-2:30 P.M.	T-1306 - Dr. Miller--Neurological physical exam; lecture
4:00 P.M.	Law 212: Attorney Grayfred Gray, Tennessee Law Revision Commission; Norman Moore, former Shelby County Welfare worker; joint topic--Welfare Rights

Friday, June 5

9:00 A.M.	Law 212: Attorney Howard Thorkelson, Mountain Legal Rights Association (time subject to change)

Morning, time and place to be announced:

Mountain people (probably Marie Cirillo and Sister Martha) to meet with medical students and follow-up people

1-3 P.M.	Amphitheater C-2209: Joint meeting with Howard Thorkelson, Marie Cirillo, et al
3-4 P.M.	Physical examination of skin, nodes and extremities (Place to be announced)

Saturday, June 6

Picnic, Percy Warner Park, beginning at noon. Everyone is to bring his own lunch. Anyone involved and interested in the project is invited!

Monday, June 8

9:00 A.M.	Amphitheater C-2209: Panel discussion on health care problems, programs and plans in Tennessee; Dr. Armes, Assistant Commissioner, Tennessee Public Health Department; Attorney Jay Loeb, Matthew Walker Health Center
1:30-2:30	Place to be announced: Bo Roberts, Administrative Assistant to Governor Ellington for state-administered federal programs, including Appalachian Regional Commission (tentative)

Tuesday, June 9

9:00 A.M.	Meharry: Group meeting for all with Dr. Barry Pless, of Rochester, N. Y., and Dr. Jack Geiger, from Tufts University; talks and small group meetings to discuss health care delivery planning.

General Notes

1. The Denver Clinic and others will be scheduled during the early part of orientation, dates and places to be announced.
2. Specific diagnosis and examination sessions for the medical people will be set up for the second and third weeks of orientation.
3. Questions about this schedule may be directed to Rod Lorend, 298-3944, or Jane Evins, 297-5441

Much of what happened during orientation is included on the schedule making up the first three pages of this report. In general, the objectives of orientation were fourfold:

1. Teach physical diagnosis to nurses and medical students.

2. Provide for discussion and setting of goals for individual groups and the groups as a whole

3. Acquaint all participants with health care problems in rural and urban areas and existing governmental assistance agencies.

4. Familiarize all participants with cultural diferences they should expect to find.

I. The physical diagnosis course consisted of lectures given by upper level medical students and clinical exposure supervised by students, faculty, and house staff. Lectures were, in general, good and adequate for the purposes they served. The clinical exposure was adequate in quality but not in quantity. The group of 200 children for whom we provided camp physicals during the last week was a real life-saver. Every attempt to provide more experience of this type should be made in the future. In addition, earlier efforts to arrange clinical exposure with good supervision in existing V.U.H. facilities are in order. During a three-week orientation, less than a week should be devoted to lectures with demonstrations during the remainder of the three weeks, each student should spend several hours of each day in a supervised clinical setting. A major deficiency was that although we were able to teach recognition of physical signs about as well as could be hoped for, we did not teach the students the flow and organization of the physical exam and its presentation in abbreviated written form. Finally, it is probably impossible to adequately train individuals to do adult physical exams when complicated pathologic processes exist in the amount of time available to this program. It follows that giving adult physical exams should be restricted to individuals who had at least two and preferably three years of medical school.

II. Nearly all participants have remarked that they did not in fact gain a good understanding of the goals of the project

at large or of the individual professional groups. Many have suggested including some sort of "community experience" for the whole. It was thought that much of the conflict and tension between individuals and groups resulted from this lack of understanding, and that we needed some way of simply getting to know each other. As regards the goals of the project as a whole, the leadership simply forgot that among the participants there were many levels of familiarity with the past, present, and future of the project. Although some would have been very bored by the process, this should have been explained in great detail. Finally, implementation of this objective of orientation will probably have to be forced upon the participants since, as experience suggests, few will realize and be ready to admit its importance.

III. Knowledge of governmental assistance programs was intended mainly for follow-up workers. In the future this should include all participants. The only suggestion is that this subject be presented more thoroughly and systematically. Knowledge of existing problems is really the desired result of the summer's work, and time need not be devoted to this during orientation except as it may be presented by any "experts" invited to speak for the group.

IV. I agree with one project participant who in effect said that the presentation of cultural differences was a waste of time since "the folks" are in fact people just like us, and the only way to know them is to live and work with them anyway. Several people suggested that everyone should read such books as Night Comes to the Cumberlands and Yesterday's People.

General

Many project participants felt poorly prepared for the work they did this summer. This was partly because none of us really knew what would be required of us--no one had ever done this before. To some extent it is acceptable since the summer is meant to be a learning as much as a serving experience. However, particular attention should be paid to the training of those non-medical personnel who worked with the Mobile Unit. All of these people should be trained at several jobs before the actual operation begins. This will eliminate much of the confusion of the first two weeks.

A major difficulty was the integration of orientation for those people learning physical diagnosis with the other groups.

I would suggest that the "physical diagnosis group" be asked to begin orientation at least one week earlier than the others as a solution to this problem.

Finally, a number of individuals have suggested beginning orientation or parts of it early in the spring. The value of this idea really depends on the needs of the group as determined by the activities planned. I would suggest the person in charge of orientation be selected by at least February 1 so that this can be done if it does prove to be a good idea.

This evaluation represents an amalgam of my own thoughts and those of many others as they were communicated to me personally, during evaluation sessions, and in personal written evaluations of the summer.

For the University

Nearly all the students with the project this summer were from Vanderbilt, and nearly all had vested interest in seeing the University concern itself wherever possible in the problem areas we found as well as the educational opportunities provided by such practical experience in the field work. With this broad goal as background, these specific recommendations are made; that

Involvement in the study of the delivery of medical care both urban and rural become a real commitment.

That this study be of the broad aspects of the many facets which affect one's health and are, therefore, a concern of any system attempting to improve the citizens' health. This includes such things as engineering, the social sciences, law, mental health, and management.

There be a revision of the policies of admission to the Medical School actively to seek for not only the potential basic science research man and clinician but also those students with capabilities of being leaders in the area of development of health care delivery both in this community and worldwide.

The proposal now being constructed by faculty and students be accepted to provide university-wide student and faculty participation with communities in the investigation of problems by these groups.

"With the approval of his major department and the dean of the college a student may be granted a one-semester leave of absence during which he retains full academic standing at Vanderbilt. This leave of absence may be granted for a program which involves academic credit or it may be granted without academic credit."[1] This recommendation applies especially to undergraduate students. This "leave of absence," with or without credit, would help to facilitate participation in community organization during the semester before the summer for preparation activities or after the summer for follow-up activities.

[1] Report of the University Committee on Teaching and Learning, April 15, 1969, Recommendation E-14, p. 61.

Miscellaneous

These recommendations apply to provate and public agencies who deal with the problem areas referred to herein. We recommend that:

The agencies dealing with health services (Public Health Department, health councils, Regional Medical Program) elicit their recommendations for plans and changes from the consumers. This quite pointedly does not mean the local power structure but should include a quite substantial portion (50% of those outside the present health care system.

Medical payment programs be broadened in scope to include payment of dental work and pharmaceuticals. (To the Welfare Department and the Public Health Department).

A means of refuse disposal for garbage, junk cars, etc., be instituted on an area basis. This most practically might be done by land-fill but in applicable regions, unreclaimed strip mines should be used. (To the PHD and the Department of Conservation)

More stringent pollution control be enacted and enforced with particular attention paid to water sources for human consumption. Assistance should be available for those areas needing to find new sources. (To the PHD and the Department of Conservation)

Legislation be enacted and enforced to control the expansion of strip mining and the reclamation of areas now disrupted by strip mines. (To the Department of Conservation and the Tennessee State Legislature)

Recommendations for the Public Health Department

These recommendations for program and/or structural changes in the State Public Health Department (PHD) stem for the most part from personal experiences with the department in rural Tennessee this summer, but the need for these changes is substantiated by statistics as well.

We would recommend to the PHD that:

1. (a) Comprehensive aggressive pre- and post-natal programs be conducted along with well-baby examinations by the PHD. These should be combined with the more commonly found birth control programs. The growing lack of obstetrical services is becoming extremely acute in a number of areas. This whole realm of health as pertains to mother and child merits quick comprehensive thorough action by the PHD.

   (b) The Nutritional Assistance Program for mother and newborn child be made available in each county of the State of Tennessee through the PHD. The acministrative costs be made available through the county court if possible; otherwise, the State PHD. An advisory board of those people receiving services be constituted to further define certification procedures and such things as transportation and location of distribution centers.

2. An aggressive treatment program for parasites combined with adequate sanitation facilities for prevention be available immediately.

3. Multi-phasic screening facilities be available through the PHD and taken to isolated areas with local sponsorship, not just visits to the county PHD office. This should be coordinated with local community owned clinics or health groups where they exist.

4. Somehow or other local or regional boards of health must be strengthened. Indigent consumer group representatives are important on these boards. Of first order is the removal of the local physicians from their control of this board. The control should be

by those groups giving and receiving the services, not those that see themselves as actual or possible competitors (LMD).

5. Topical fluoride be applied in school for those children not drinking flouridated water; and a pre-school program to do the same be brought into existence.

6. Rhogam should be made available to all mothers with Rh negative problems. Here we have the means of preventing all future Rh problems if Rhogam is available. It is criminal for this potentially solvable problem to ever occur again.

7. Medicaid and Medicare programs be broadened to include payment of dental work. The Medicare program should include payment for drugs.

8. A program should be available to cover the medical expenses of those people unemployed not qualifying for welfare and not eligible for Medicare. It is unnecessary to remind you of the need for the development of clinics or OPD service.

9. A means of disposal for refuse (from garbage to dead animals to junk cars) be initiated on an area wide basis. Where practical this should be by land fill and where they exist unreclaimed strip mines could be use for this.

10. There be much more stringent pollution control with particular attention being paid to water sources for human consumption. Assistance should be available not only for testing but the discovery of new sources and facilitation of this development. You are familiar with the prevalence of hepatitis in much of this area in which we worked.

11. Where health councils and community health projects exist, coordination with and creation of new programs when feasible should be available to these groups.

12. Perhaps most important of all should be the change in attitude among the rank and file of the PHD. Among a substantial number with whom we came in contact an air of cynicism and pessisism concerning the possibility of any change or improvement prevailed. This attitude was also displayed with respect to the large

majority of people whom the PHD serves. It was more a matter of let's do what's necessary according to our rules rather than let's do whatever is necessary to solve the problem. A creative, aggressive, enthusiastic atmosphere was definitely not present. To be successful (effective) it must be. Transportation is a problem. An attitude of "Let's bring health to the people" would be better than "Let them come to the county seats for their immunizations."

13. That additional physicians, nurses and assistants be added to the staffs of the county health departments by changes in state law if need be to get around uncooperative county courts. In addition, nurses should be given further training in order to be able to conduct pre-natal and well-baby clinics themselves. A great deal of medical assistance could be rendered in the home by these nurses with advanced training and permission to for example listen to chests and hearts, look at ears, etc. Given new exciting programs we are convinced that recruitment problems can be solved.

APPENDIX

List of Participants

Goals of Individual Groups

Questionnaires Used in Evaluation

- For students
- For doctors

Personal Reports

- From Mobile Unit Staff
- From Follow-Up Staff
- From Law Students
- From Mental Health Students
- From Town Project Students

Map of Rural Project Route

Newspaper Articles

Outline of New Elective Courses in Vanderbilt Medical School

Letters from Physicians, Community Leaders, Health Departments, Faculty

PARTICIPANTS
STUDENT HEALTH COALITION 1970

Rural Group

Milton Anderson - Medical
Jean Austin - Nurse
Ann Baile - Nurse
Linda Bell - Nurse
Karen Blaydes - A & S
Kathleen Brewer - A & S
Richard H. Burr - A & S
Richard A. Davidson - Med.
John Davis - A & S
David B. Dawson - Law
William W. Dow - Medical
Elizabeth Dow - Medical
John Draper - Grad.
Margaret Ecker - A & S
Jane Evins - Law
Carolyn Gayle - A & S
Sarah Graf - Nurse
Mary Ruth Hall - A & S
Frances Hooks (Volunteer)
Margaret Ingram - Nurse
Kay James - A & S
Carolyn Keith - Nurse
Carolyn Klyce - A & S
Robert Leonard - Law
Rodney Lorenz - Med.
Charles L'Hommedieu - Med.
Ann Lovering - Nurse
Linda McFadyen - (Peabody)
Kathryn McMillan - A & S
Ronald M. Massey - Med.
Patrick Maxwell - Med.
Bonnie Maxwell - Nurse
Barbara Miesse - A & S
Darrell Paster - A & S
Dean Rivkin - Law
Brenda Rivkin - Nurse
Arnold Rosenfield - Law
Charles Schiff - Engineering
Deede Schmidt - Nurse
Elizabeth Scott - A & S
Virginia Solomins - Nurse
John B. Sperry, Jr.
Charles Suggs - Med.
(Georgetown)
April Taninecz - A & S
Henry Unger - Medical
Stanley Von Hofe - Medical
Barbara Von Hofe
Elizabeth Ann Weil - Nurse
Robert White - Law (Columbia)
Linda Anne Watson (Peabody)
Phyllis Rubin (Peabody)
Joe P. Moss, M.D. - Instructor
Randle Moss - Technician

Urban Group

Ed Anderson - Vanderbilt
Sandra Bates - Meharry
James Collier - Meharry
Clyde Heflin - Vanderbilt
Joe Holiday - Vanderbilt
Errol Quintal - Meharry
Margerie Scott - Meharry
Frank Stevens - Vanderbilt
William Watson - Vanderbilt

OBJECTIVES OF MOBILE HEALTH UNIT

Justification

Only in that something lasting can come of these efforts. Delivering this service enables us to work toward better systems concerned with solving current problems.

Objectives

1. Formation of or development from an existing, representative group in each of the designated areas.

2. Working with the local group and in conjunction with our "follow-up workers" to provide a week-long open health operation involving:

   a. Physical screening of all persons (laboratory and physical analysis)

   b. Health education measures (providing information, films, etc.)

   c. Preventive measures as topical fluoride application and immunizations

   d. Mental development screening (in certain areas).

   e. Arts and crafts emphasizing child involvement with expression of creativity.

3. Again, in conjunction with our follow-up workers, determined efforts to procure additional evaluation and treatment for those so needing through local doctors and existing programs . . .

4. . . . and in doing so work toward means of establishing new channels of communications and service in the health fields.

5. Efforts toward listening to thoughts of the local people to determine their priorities and assist them where possible in working toward solutions.

6. Involvement of local persons in the health operation in an effort to stimulate interest (especially among the young) and possibly to influence vocational choice.

7. By working and living with these people, learn from them some of the many aspects of life and mankind not able to be taught in conventional education.

8. Being aware of our own attitudes and the influence of this summer's experience on them.

9. Broadening our horizons as to the current complexities, problems, and failures involved in the distribution and delivery of health care.

10. Observing and evaluating the effort in teaching physical diagnosis in a short amount of time to health persons of limited training (first year medical students, nurses, and nursing students) and in their resultant ability to handle "well-patient" physical examinations.

11. Obtaining the involvement of numbers of the faculty of Vanderbilt Medical School in an effort to stimulate their interest in areas of health care delivery to the community.

12. Through our experiences of this summer consider the adequacy and direction of our current medical education and how it, if so needed, might be implemented or altered.

13. Finally, leaving with each local group our knowledge of the evolution of nurse-run clinics or other facilities and approaches which have been developed in communities similar to their own and directions which might be pursued in their own development of some type of facility.

FOLLOW-UP GOALS

1. To prepare for the arrival of the mobile unit by seeing that the community has all plans made.

2. To carry out follow-up work on individuals with medical problems:

   a. by making the necessary preliminary connections with area medical resources.
   b. by getting people to doctors
   c. by arranging financial assistance when possible and when desired.

3. To make plans for long range follow-up work to be conducted by the community: (i.e. to have the community make plans)

   a. Community responsibility for individuals through the health council or through individuals.
   b. Continued Vanderbilt involvement through University participation or through organizations (VIFA).

4. To come to know the community on as many levels as possible and to establish some base of friendship and trust, a kind of rapport.

   a. Identify leaders
   b. Know structure and procedures of the Welfare Department, Health Department, local doctors, local medical associations, comprehensive health plan, community government, county government, citizen participation on public health board, etc.

5. To learn the priorities and problems of the community, as it sees them.

6. To influence Vanderbilt to use its expertise in the resolution of community and health problems.

7. To raise the general health and community development consciousness of the communities.

LAW STUDENT PROJECT OBJECTIVES

1. To develop within the people of the community an awareness of their health and welfare rights.

2. To accumulate pertinent information which will be used to attract legal assistance to the area.

3. To provide information concerning federal, state, and local programs and to assist local people in recognizing problems and developing solutions to them.

4. To observe problem-solving techniques of other disciplines in an attempt to broaden our perspectives and to maximize the efficiency of the interrelationships of the disciplines.

5. To educate ourselves on social welfare laws and their application in practice.

6. To observe the attitudes of a rural mountain people toward the system of law unique to the area.

7. To document and interpret institutions which affect the area.

MENTAL HEALTH GROUP OBJECTIVES

(Smithville and Clairfield Areas)

1. To administer Denver Development Screening Test for purposes of gathering useful information and locating those children who need special attention.

2. Through home visits, to develop in mothers an awareness and knowledge of child development, nutrition, prenatal care, home safety, etc.

3. To develop mothers' organizations, through which to begin such programs as day care, crafts, a home nursing course, recreation, etc.

4. To guide mothers to available local services and to help with those services, where needed.

5. To secure such state-sponsored programs as day care centers and special education teachers or speech and hearing teachers, where possible.

6. To gather information on local services and prepare recommendations for improvements and additions.

7. To display simple homemade toys on the unit and to teach mothers to make such toys.

8. To provide for continuation of useful programs beyond the summer.

9. To gain a greater understanding of rural health care delivery problems.

10. To supply materials to all mothers of young children concerning early childhood education, hopefully Ways in Which Babies Grow and Learn: Activities for Infant Education, Denver Child Development Center, or materials similar to this publication.

    Supply will be done:

    1) As mothers come through mobile unit
    2) In mothers' meetings. Hopefully, follow-up people will be able to begin these groups
    3) To education, health personnel already in area.
    4) To mothers through home visiting.

11. To visit homes of severely retarded children, upon invitation, to offer assistance. Assistance:

    1) Hooking up parents and child with any service in area.
    2) Hooking up parents with other parents. (This is how parents groups begin)
    3) Programming for individual children.

12. To work in whatever programs are existent (day care, day camp, recreation)

13. To offer assistance to personnel of (12), upon invitation, of a professional nature as opposed to practicum.

14. To offer long-range suggestions concerning programs observed, if asked, at the close of the summer.

15. To set up in the unit (or nearby) a display of easily made toys and materials useful in early childhood education.

16. To plant the seeds of cooperation and joint effort between the Child Study Center and the Medical School with the long-range goal of some community-oriented continuing program.

We recognize that limitation of time and personnel will make it impossible to achieve real progress in more than a few of the above areas, at best. However, in view of the need to adjust to the wishes of the community and in view of differences in character and resources between Clairfield and Smithville, a range of plans were discussed to provide for preparedness without sacrificing flexibility.

SMITHVILLE PROJECT GOALS

Compiled from individual goals of: Ecker, Austin, Schmidt, Bell, Graf, Baile.

Goals

1. To become sensitive to community needs and priorities - Develop or seek out a viable community group (in our case, outside OEO influence) (Mother's clubs, day care center), (a) so that both insiders and outsiders have an instrument with which to measure the needs and feelings of the local indigent citizens; (b) so that any projects related to their major concerns that we assist with will be taken over and continued after we leave.

2. To insure that all people seen by the Mobile Unit who need additional health care are visited by one of our group, that their records are discussed with the appropriate physician with our recommendations, and that an attempt is made to insure that people are able to get to the approoriate physician (investigate community resources).

3. Record progress and group decisions, action, failues, suggestions for future, etc.

Special Interests

1. Determine the need for a prenatal clinic in DeKalb (and hopefully Cannon) County, and set up such a clinic if feasible, (a) assess the degree of cooperation between local groups, Public Health Departments and local doctors and build on this; (b) determine if the prenatal population will utilize the clinic and survey attitudes of these women regarding prenatal health care; (c) compile Rutherford County clinic statistics to help in establishing the new clinics.

2. Collect necessary Rhogam research data from each of the three counties and make appropriate recommendations.

3. Follow-up on children who score low on the Denver Developmental Screening Test--will involve primarily home visiting--investigate possible causal factors (nutrition, safety measures, family structure, health priorities among others) and ways we can assist in alleviating developmental problems. Involves careful record keeping and constant evaluation of the implications of the test.

4. Provide assistance as possible in well baby clinics - in what ways might mothers be trained to assist, be taught health

care while at clinic?

5. Through home visits and work with community people, assess interest in setting up a home nursing course - this must be a community organized project to be effective.

VANDERBILT-MEHARRY URBAN HEALTH PROJECT GOALS

Welfare Disability Applicant Program

We as a group decided from the beginning of the project that we must establish certain goals which we hoped would be helpful to the welfare applicants, to personnel in the Welfare Department, and to us as medical students. As a result we compiled the following list of goals:

1. That our project for the summer should be a joint Meharry-Vanderbilt one.

2. That we should compile a list of suggestions during the project which possibly might improve the system of providing physical examinations for disability applicants.

3. That we should show concern and feeling for the patients to reassure them that we are interested in their problems.

4. That we endeavor to seek out the available medical resources that can be used by the didability applicants and to give this information to the examining physician who could then pass it on to his patient.

5. That medical students use this project as a source of clinical experience and training.

6. That we assure applicants of our help and assistance in getting on the welfare program.

7. That a system of referral and follow-up be established to insure the best evaluation of the patient's condition.

Foster Care Program

We attempted to accomplish four goals in our Foster Care Program.

1. We hoped to learn about the State Welfare Department's Foster Care Program and we attempted to help this program by giving needed screening physicals and immunizations.

2. We wanted to learn how to deal with children and especially with emotionally disturbed children.

3. We hoped to compare the mental development of the foster home children with a control group of camp children from a similar socio-economic class.

4. We wanted to be sure that the foster home children received any needed follow-up care.

EVALUATION QUESTIONS

For Students

Job:

Location:

Duration of work:

RE mobile unit:

What is your overall evaluation of its functioning? equipment; supplies supervision; efficiency

How did the mobile unit people (medical and others) function? were there tensions between professional groups? did some groups feel overworked? what changes, progressive or regressive, occurred in the work of the mobile unit staff--if any? comment on the scheduling of the unit's work. What possibility, if any, do you see for the future planning of satellite health fairs, such as was done in Kentucky Hill and Elk Valley? Was your work interesting? What kind of service did the people at the health fairs get?

Evaluate the housing situation--i.e., people living in communities--during the health fairs. Did you ever live in a home during a fair? Was the experience of any value to you? What sort of housing arrangements would you suggest for the mobile area for future projects? Why?

What communities were the best to work in? Think carefully: why was working in these communities a pleasure?--facilities, attitudes, gratitude of people, challenge of work, numbers, etc.

What changes in basic structure and format of the mobile operation would you suggest and why?

What impressed you about the people you encountered this summer?

Follow-Up People and Local Law Students

Sketch your community:

What leadership existed within the community as a whole, when you began living there?

What sort of health group, if any, existed? Describe their level of organization, number of participants, etc.

How did the health group--or the group with which you worked--fit into the local organized structure of the

community? Was there measurable opposition to the health group--if so, why?

Describe your reception into the community. What were hostilities, and where did they come from? Of what duration were they? How did you deal with these hostilities? How did you conceive your role, both as an individual and as a part of a working twosome?

Did the health group progress any, during the course of the summer? What influence did you feel that you had on this development? What specific problems was the group dealing with during your stay?

What was the general community reaction to the health fair? What role in health did the community conceive for itself AFTER the fair? Were you instrumental in this role development? Did the community follow through with this role?

Try here to think in terms of your county. Describe the medical services offered to indigent populations--and then, to the general population--of your county.

What deficiencies of medical care did you see in your county? List and/or describe them.

What sort of medical care was immediately available to members of your community?

The best you are able, describe a (or more than one) feasible concept for developing health care in your county--or, if it is more practicable, in your general area, facilities--transportation, equipment (mobile or stable), staff, funds. To what extent could local groups participate in the planning and execution of such facilities? To what comparable extent would the feds need to be involved? Estimate the feasibility of such plans, in terms of the community's development, money and leadership available, public health and governmental plans, etc.

Now, think in terms of public assistance programs. Roughly, estimate how many people in your area were on some kind of public assistance? What sort of cooperation did you get from social security, welfare, etc., people--and what demands did you put on them?

LAW STUDENTS ESPECIALLY: DESCRIBE YOUR UNDERSTANDING OF HOW WELL EACH SYSTEM FUNCTIONS IN YOUR AREA: PLEASE OFFER SUGGESTIONS ABOUT SUCH.

Did the people have any reservations about participating in public assistance programs? Describe them, if they existed.

General Questions

What was your impression of the "dignitaries" which were ushered around during the summer? What feelings do you recall having when they were around?

Do you think that this project has proven anything? What? (To you, to the medical profession, to the people of the mountains, to the local doctors, to V.U. Medical School, to the government, to the public (via press), to your peers, etc.)

What questions has this project posed? Has it answered any of them, or are we working toward answering any of them? Which ones--and what answers do you predict?

What should happen to the data we receive from the project? Should it be released to any group--would we pressure to change medicine? What do you think would be the best plan--and which groups would we contact for action?

Think back, in realistic terms, over the summer.

What was the actual function of each of the initial groups?

medical students
nurses
accountant
follow-up students
secretarial workers (mobile unit)
law students

Do you feel a need for additional personnel in future projects? What kinds of workers? How many?

How would you change things in rural health care delivery if you could?

For Faculty Evaluation

1. How would you evaluate the operation of the Health Fair, i.e. quality of physical examinations given, efficiency of the Fair as a whole, etc.? What problems were most obvious to you? In what areas did we do best?

2. How did you view your role as a faculty member while you were visiting? How would you define the ideal role of a faculty member working with the project on a short-term basis? What about a long-term relationship between the project and the University as an institution? How do you feel about students calling on faculty for assistance?

3. What effect, if any, do you think a student project of this kind might have on improving medical health care delivery? What role, if any, do you see Vanderbilt University Hospital playing in these changes? Would you want to see Vanderbilt help to staff a rural hospital or clinic in East Tennessee? Why or why not? How do you feel about the proposed nurse practitioner training program - will it be useful or impractical?

4. If you were asked to help us another time, would you do it? If not, why not? If so, why?

For Local Doctors Evaluation

1. What did you think of the mobile unit itself in operation--its efficiency, effectiveness, quality of work done?

2. Can you evaluate the reaction of your community as consumers to the Health Fair--positive or negative; any developments in better health care awareness?

3. Of what quality, in your opinion, were the lab work-ups, physicals, and diagnoses? How do other doctors in and/or around your community react to them? Have there been problems with referrals of new patients or patients on public assistance?

4. What long term effects do you feel the project has had on your community, if any? Did the project uncover or create any new problems in your community? How would you change any phase of the program--planning, Health Fair Week, follow-up, community work?

5. Would you want us to return? Why or why not?

Personal Evaluation

William Dow

This evaluation must be read in light of the fact it is being written December 6, 1970, with more perspective of long term effects than others which accompany it written earlier in the fall.

The four major goals which I personally defined for the project were the following:

1. What could be done along the lines of community organization and advancement in the area of health care?
2. To put on "health fairs" in order to detect immediate health problems and lend enthusiasm to community organizations.
3. What sort of additional changes could be brought about during a summer of direct exposure to the lives and medical problems of the indigent?
4. As a result of addtional and organizational changes, could alterations be made in the training programs for health personnel and the agencies charged with delivering this care?

In looking retrospectively community organization could probably be classed as our most successful endeavor. In each of the communities (with the exception of those where we were sponsored by the OEO--Smithville and Murfreesboro), there now exists a viable moving health council composed of indigent citizens. These councils are in the an array of stages toward providing improved health care. White Oak and Clairfield have operational community clinics; Briceville has the land, $2000 and the promise of a building; Deer Lodge has obtained the services of a physician with Project Concern until such time as they build their own clinic; Habersham has a building, a growing treasury and is looking for staffing; and members of the Sneedville area health council are screening for hypertension and diabetes while planning for a mobile clinic to be used within the county.

I feel these results indicate the success of the organizational work done and the actual and potential long-term results created.

The health fairs must be observed from a number of perspectives. In terms of community response they were each tremendous successes, yet this very fact that large numbers of people responded meant that there were too many people. This prevented

the examiners from taking the amount of time that would have been optimal for the investigation of the medical problems concerning each patient. Laboratory functions were performed on all patients and at this point I don't feel the laboratory data was compromised by increased numbers. The statistics of the medical problems found will be available by the first of the year.

As an educational endeavor the health fairs were extremely valuable as far as exposure to pathology. However, there was not enough time to take full advantage of this by at least modest reading or discussion. This is a situation I feel can be easily remedied with more personnel and supervision.

As to the follow-up from these fairs without yet having the statistics, I can still suspect that the most comprehensive will be in those areas which have their own clinics (Clairfield and White Oak). This is the one outstanding factor involved. Although more time for follow-up may be taken and this involves medical students and nurses, the fact remains that these people will be seen and followed in community clinics, whereas because of financial obligations and distance they will not be by the LMD. This is particularly true of the indigent.

The third goal, that of changing attitudes, is documented in this report. To this I add my own personal observations. As a group the participants are much more sympathetic to the needs of the medically indigent. To a varying degree they realize the inadequacy of their education. To a somewhat less degree, do they yet understand the lack of movement by either the medical profession or health agencies to accept responsibility for the inappropriateness of the system or its improvement. Not fully realizing this they have not yet seen the need for fundamental changes in the present system. It would appear that understanding correlates proportionately with how close the problem is to oneself. In this case many cannot yet fully view the problem from the perspective of the people. This takes time, experience, and that series of encounter which finally creates the required sensitivity.

The importance of the community organization has for the most part gained recognition. Also very gratifying has been the support given to these groups, yet allowing the organizations to unquestionably "run their own show."

Fourthly, what about the educational institution? Vanderbilt has now started a nurse practitioner program and has committed itself to its development.

As for faculty, there is on the part of many the admission that yes, it is time to improve health care delivery. The amount of understanding as to what this involves or its appropriateness

as an academic endeavor continues to lag. However, a faculty committee has been appointed to recommend to the Medical School what moves it should make in this area. These recommendations will concern the creation of a center responsible to the Dean of the Medical School for research into health care delivery and all its various facets. It will depent a great deal on student participation and will most likely become the university home for future student projects. That the Medical School should and will do this I am quite convinced.

Perhaps one further point that is helpful in overall evaluation is that a viable student organization remains. For all of its diversity of ideas and opinions, it continues to plan for next year (meeting twice a week which says something in itself when it attracts even on slow nights at least a dozen students). A clinic is being operated in Nashville once a week in a day care center and once a week a local physician accompanied by students holds clinics alternating between Clairfield and White Oak.

I ammore convinced than ever that if changes are to be made the time for greatest change in personnel stance is while one is in school. This is said in light of, among other things, comparing reaction of faculty vs students who were with the project during the summer. Therefore, I feel this sort of activity--exposure to problems and consideration of and participation in possible solutions--is essential in one's education and training.

That this type of approach (health fair--community organization--?) brings results is obvious. If there is a better way, I think the kids will try and find it.

Personal Evaluation

Rod Lorenz
Vanderbilt Medical Student

In this evaluation of our summer's work, I have directed my thoughts to three very general objectives which we set down as our reasons for having a summer project: 1) Service to the people of the communities involved, 2) self-education in the realities of American rural health, and 3) influence on the future of Vanderbilt University. I have assumed this direction because circumstances allowed me to participate in all phases of the project and prevented me from gaining in-depth experience at any. My point of view is, therefore, necessarily that of the generalist rather than that of the specialist. For example, while I cannot contribute to improving the efficiency of the Mobile Unit, I can offer an opinion on its value to the communities we visited.

Our services to communities might be considered under two broad categories, those strictly medical and those of a broader sociopolitical nature. These two kinds of services are exemplified by the technical services provided by the Mobile Unit and by the community organizing done before and after the Health Fairs. As regards the former, we will be able to show quantitatively that we have been responsible for the diagnosis and treatment of a certain amount of disease. The value of this service can, of course, never be put in quantitative terms, but the positive value of this service to people cannot, in my opinion, be denied.

Several aspects of screening and follow-up of diagnoses made deserve further comment. First, like many others, I have wondered about the possible disservice done by allowing partially-trained personnel to participate in health screening. It is entirely possible that a patient might disregard symptoms because he had been mistakenly told by a medical student that "all is well." The key to this issue is adequate supervision. There were times this summer when there were simply not enough doctors to supervise even a fraction of what was done. Fortunately, these times were infrequent. More important, I think, is the qualitative deficiency in the supervision. Many of the faculty were present on an "available for consult" basis. This is not sufficient. We need more active (perhaps activist is a better word) supervision if the best in health screening for the patient and education for the student is the desired end. (We did have this kind of supervision from some faculty members). On the other hand, we as students were to a degree responsible for the passive supervisory attitude. Being somewhat paranoid about faculty attitudes, we were sometimes more concerned with making an impression or simply with telling one

story, than with getting active participation. It is hoped that in the future faculty who are more knowledgable in what we are doing will want and be able to contribute more. In short, I think the ideal is bilateral student-faculty activism in an experiment in health care delivery.

Another problem, already much talked about, is the volume of patients we saw this summer. The effect this had on the quality of the job we did, on our ability to relate to each other effectively, and on our ability to relate to the people, has been discussed at great length. I would only add that the great numbers of people, the long hours at repetitive tasks, were conducive to viewing our job as just that and no more--a job. It is my feeling that when physicians begin to see medicine as a job, they also begin to see medicine as a business; they begin to see medicine as diseases, not people. We should hope for better than that from ourselves and our colleagues, and avoid whatever has the potential of blurring that vision.

An acknowledged shortcoming of other health screening programs in rural areas has been the lack of follow-up on the diagnoses made. We set out to remedy this deficiency and designated certain people to be responsible for follow-up in each community. This one aspect of our project is what made it worth doing. On paper our results are good. We were able to inform everyone of the results of their examination and to advise further investigation or treatment when it was warranted. There is evidence that a good percentage of those advised to see their own doctor again did so, and that those seriously ill received professional attention. However, what was done still leaves much to be desired. Too many follow-up decisions were made on the basis of time and personnel available. Too many priorities were set on the basis of what we could do, rather than what should be done. Often people were informed by letter of a diagnosis requiring further attention when a personal visit to the home should have been made, with time to educate the medically unsophisticated mountain dweller. With a few simple lab tests (e.g. blood glucose) we could have eliminated the expense and inconvenience of many of our referrals. Finally, we needed more time to secure volunteer aid from other professionals, such as dentists and optometrists, to be available to communities as a continuing basis. Where we were able to make this effort we were often successful. In summary, we cannot assign two people to a "virgin" community with a Health Fair scheduled in July or August and expect even reasonable quality follow-up. We must do better than this in the future.

The second kind of service we have provided to communities, the organizing of the medically indigent people, may or may not be considered a service depending on one's political bent. Disregarding

political attitudes, however, it is of value in that it gives permanence to our efforts. Few will argue with this strictly pragmatic value of the Health Councils we helped to organize. Furthermore, the Health Councils have given these poor people a means of dealing with an established power structure which often ignores them and sometimes actually exploits them. I will never forget one illiterate mountain man who told me of the pride he had for his town, which had been looked down upon for many years, because the people of the town had finally stood up and done something for themselves. Change never occurs in any biologic system unless there is some conflict between existing forces. It is my sincere hope and belief that we have created new conflict, and thereby caused some change, in a few towns in rural Tennessee.

Our second objective in undertaking this project was to educate ourselves. We felt that standard medical education at Vanderbilt does not give us the opportunity to appreciate the vast problem of delivering health care to people. Through this project we hoped to have that opportunity. An evaluation of the success we had in reaching this goal is most important if we are to justify its existence to and gain greater support from our colleagues and our teachers. First, there should be a clear understanding that our project was not a good place to learn orthodox, disease-oriented medicine. True enough, the experience was of great value in gaining practice in techniques of physical diagnosis, and in gaining refined understanding of the variation of normal. But let us not try to deceive ourselves. The patient load was too great to spend much time learning Cushing's disease or peptic ulcer disease. In fact, it is my feeling that the teaching and learning of orthodox medicine <u>should</u> be of secondary concern in this type of project. First, the needs of the population with which we are dealing are so great that I think it right that we try to see as many individuals as we can, and that teaching of disease-oriented medicine be made secondary to the needs of the people. Second, our educational efforts should be concentrated on those things we cannot learn within the walls of Vanderbilt Hospital.

Unfortunately, I do not think we succeeded as well as we might have in learning about American medicine as it is seen by the rural consumer. This is especially true of those who worked strictly on the Mobile Unit. Each of us must spend significant time at follow-up work in order to understand the difficulties when medical facilities are so scarce. We must talk with families about their health problems to see how their culture affects health care. We must be good enough friends with the people so that they will tell us each personally what is wrong with their town and why--as they see it. We must work closely with local health departments to understand why they sometimes do not behave as we think they should. We were

not able to do these things because there were not enough of us to finish what had to be done. We were forced to sacrifice breadth of experience for the individual for efficiency.

In spite of this, most of us have a better understanding of the politics of medicine, or perhaps in better words, the extent to which medicine is political. We are now more acutely aware of the problems that exist. None of us will be able to remain in Vanderbilt Hospital, or our private offices, satisfied that we are doing all that a physician should do.

A third goal discussed in our planning was to influence the direction of Vanderbilt University. We felt that our school was ignoring the most vital issues in medicine today, and that we as students might help break our school out of the laboratory into the world where people are living. Whether anything concrete will happen remains to be seen. I do know that most faculty and administrators who visited us were impressed beyond what we had hoped for. I think they were impressed most by what students can do. I think they learned to understand students slightly better. I doubt that they are now any more aware of problems of health care delivery or of the sad state of American medicine.

What we are talking about--what this project is all about--is in reality a new system of values--a system of values which is different from that held by most of our teachers and colleagues at Vanderbilt. It is important that we realize that if we ask an older generation to assume our values, we are apt to be permanently and severely frustrated. We are more likely to be successful if we aim at convincing others that our values are worth expression, to the extent that they will not only allow us to assert our values in action but also actively facilitate such action. I do not expect present Department Heads to leave their laboratories, but they might well hire faculty members whose concerns are similar to ours.

More than anything else, I think this project has proved that those who say the Establishment is deaf to new ideas are dead wrong. I say this because we <u>have</u> been heard. We have been heard because we have expressed what we believe in <u>positive</u>, <u>useful action which is meaningful to the lives of people</u>. The days when protests and strikes were effective aregone. These are no longer effective tactics in causing change. And justly so, simply because the values worth holding are only those which motivate people to positive, meaningful action. This is what I have learned in this summer's work. I only hope--it must happen!-- that those who have the power will continue to prove me right.

Personal Evaluation

Betsy Scott

Job: Clerk

I would like to start by saying that I cannot give a completely objective evaluation of my experience this summer. This is partly because, as a clerk, I did not come in close contact with the medical problems that were encountered, and also because my overall impressions are more derived from an emotional analysis.

I did not like orientation. There was no strategy I had to prepare, no particularly relevant (to my job) lectures I had to attend. When the summer started, I was not aware of long-range plans for medical health in the area, and somehow despite three long weeks of talks and presentations I never developed a clear idea of my role in the organization or of the group's role in the community. I think everyone should have an idea about the aspirations of the group as a whole and the aims of each "professional group." Everyone should know something about the problems encountered in medicine, law and general community relations. Too many of the urgently required lectures were just a waste of time. The only lectures that stand out at all in my mind were the ones by the "folks" and by Jack Korn. None of the others prepared me in any way for the work I was to do or the experience I had.

Perhaps my experiences with the people were better than usual, but I did not encounter as much hostility and "backwardness" as I was led to expect. I think, perhaps, that we were all a bit paranoid about hurting their feelings or alienating them. For the first few weeks, anyway, I was too apprehensive about impressions--clothes, speech--just fitting in. It was not until I began to relax and do more of the things I wanted to--and naturally--that I began to feel natural in my surroundings. (One example is the question of girls wearing pants).

One of the most enjoyable parts of the whole summer was living with different families. For one, it was the only time I was really free to get to know the people as more than just objects of interest. In Clairfield and White Oak, I spent every evening on the porch swing whittling and talking as the evening passed, getting, for the first time, a feeling for the people, their life styles and their thoughts. It was very frustrating at times--when I knew I couldn't help as much as I would like--when I knew that for me the summer was an educational experience and a test of endurance, which for them it was an inescapable way of life. It was hard at times when they didn't live up to my "romantic" idea of "folks," but in final analysis, once the facades had been broken down on both sides, I appreciated them much more.

It is true that it is necessary to "get away from it all" at times. There were days when my only thought was to finish work and go into town for a beer and some relaxations with friends. But I think that everyone should have had the opportunity to live with families for at least half of the summer. It was regrettable that many of the medical students were so antagonistic. Perhaps the problem would never have come up if from the beginning everyone had stayed with families and been able to appreciate the privilege rather than regret the idea.

One of our major problems was the misunderstanding between the medical group (or the entire mobile unit) and the follow-up people. I think that much of the basis of this misunderstanding was the ignorance that each group had for the work of and demands upon the other. The follow-up people only worked with the unit for one week and could not understand our reluctance to see as many people as possible despite exhaustion. They were understandably disappointed when the fair for which they had spent weeks of preparation was not met with an equal air of excitement by the mobile unit people who had been through it all before and for whom it had all become rather methodical work. On the other hand, the people on the mobile unit did not appreciate the hard work and mental strain that went into the follow-up work. I think there are several possible solutions to this. I still think it is important to have at least two people in each community to do planning and preparation for the Health Fair. But I also think it would be good to have about six or eight extra follow-up people who would be free to travel around wherever help was needed--whether on the mobile unit or especially after it had left and the paper work and home visits were being done. I also think that, if at all possible, the people on the mobile unit should spend at least a week each working on follow-up (during the 8 week period). This would give everyone a broader conception of the overall work being done and a more sensitive understanding of the other roles involved in the project.

I thought the satellite projects went well although I think it is important that more planning go into these ventures, too many of the charts and x-rays were lost or laid aside from Kentucky Hill and Elk Valley. With more organization perhaps these trips could be extended to several days and cover more territory. This, of course, all depends on the number of persons available to work away from the main Fair. Perhaps if there were three clerks, one could always be in charge of the various satellite operations. She could be responsible for records, personnel, pre-planning and supplies. The clerks could each spend one or two weeks rotation on this job and thus not have to spend the entire summer at the same desk.

The communities I enjoyed best were Clairfield, Briceville and White Oak. The housing was excellent and the people were all very warm and receptive. We were busy, but had developed enough efficiency and ease that there was not as much strain and there was plenty of time to enjoy the people and the area. I also think that in these communities, more than any others (with exception of Habersham) we really felt as though all of the people we saw needed our type of health care delivery and we were not just seeing people who were taking advantage of free care.

(As a sideline, it is amazing to note the hostility that the group developed towards "rich" people who came through the unit for physicals. What is in Nashville middle-lower working class is middle class in the mountains and somehow being around them made me feel somewhat dissatisfied that I was not with real "folks," or that somehow they were not genuine because they had some conveniences that the others did not have. I know that I was happiest when I was staying with a family that had a house with no running water, an outhouse, and green beans and cornbread for every meal)

Finally, I think that this project has proven a great deal. It has given us a better understanding of some of the complexities involved in a massive program of free health care delivery. And yet it has also proven that much can be accomplished by otherwise "unqualified" people. Hopefully as we develop and expand our program, we can serve as an example to others. It is a fine training ground in clinical work for nurses and medical students and it is (becoming) an efficient way to give the most care to the greatest number of people as unexpensively as possible. Because it is student run there will always be new ideas and a good amount of energy and initiative. We have set up the structure and the example for others to follow and take our place when we have gone. There is much to be worked out, but I am optimistic because we are just the beginning.

It has proven, above all, to be the best education I have ever had.

Personal Evaluation

Henry Unger

The best way for me to evaluate this summer is to first list what my goals were and then to proceed to evaluate how effectively they were met.

1. To present a new method of rural health care

2. To set up consumer health groups (councils) and demonstrate to them quality health care.

3. Delivery of quality health screening with adequate follow-up.

The first two goals I have little firsthand knowledge; the third I am quite familiar with.

1. Presentation of a New Method for Solving Rural Health Needs

The method that we proposed consisted of periodic screening of the population and the use of the nurse practitioners. The success of such a program can only be evaluated objectively as to feasibility. Objective data as to incidence and adequate treatment is lacking. What little "hard" data we have has been inconsistently gathered and poorly recorded. If we ever plan to objectively evaluate such a program better controls will have to be placed on our data collection.

Personally I think such a system can work. I envision during the summer months groups like ourselves screening the rural population and nurse practitioners setting up small clinics where they would treat acute problems themselves, e.g. infection, and monitor the treatment prescribed by a travelling M.D. who would visit the clinic periodically.

2. Health Councils and the Demonstration of Health Care

The former was the function of the follow-up personnel, the latter the mobile unit. In only White Oak and Briceville did I see a truly viable consumer health group in evidence. It is very encouraging that in such a very short time we were able to get two communities so interested in their health care that they would try and do something to improve it.

The major problem I see in setting up health councils is identifying the true community leaders. We missed badly in some

places. I can see no feasible way of identifying the right people every time--we can only try, and if wrong find a "new" leader the following y ear.

As for demonstrating quality care, we had an excellent facade. In meeting this objectively that is all that is necessary. For we demonstrated the mechanics of a health delivery system that should be available to all. They have something to shoot for--we are the only one to know we gave them poor examinations.

3. Delivery of Quality Health Screening with Adequate Follow-up

a. Physical examinations - adult

As for the mechanics, they were quite good. However, to ask a first year medical student or even a second year medical student to give a quality physical examination ludicrous. (In my speaking with William Dow I began to wonder if quality ever entered into his thinking). God only knows what I missed (that is probably a good thing). Given the fact that we did not have adequate personnel, we did an enviable job. If we are talking about the future with adequate staffing, it is a different story. In my opinion only those medical students who have completed the third year of medical school should be allowed to give adult physical examinations. Adult physicals are the most complex and we should put our best trained there.

The amount of paper work for women's examinations at points became staggering. The examiners need more help in both the examination phase and in doing the paper work. More ancillary personnel is needed--a ratio of one ancillary person to each two examiners is minimal and this ancillary person should not have other functions, e.g. running an ECG machine.

b. Pediatric examinations

This function was handled by the nurses for the most part. They did an excellent job, but again, what was missed?

I was quite disturbed about the attitude of some of our nurses toward the end of the summer--they began to think they were doctors. (Maybe we gave them too many accolades and not enough criticism).

We should use nurses both as nurses and as pediatric examiners. Furthermore, upcoming juniors should be used as much as possible here. I feel I was better equipped for detecting physical signs than I was in trying to figure out some complicated adult pathology.

Our follow-up personnel were not trained to understand medical dispositions of disease and cannot be trained in a two week period. Medical follow-up in each town should be directed by a medical student--upcoming junior would be ideal. He should have undergraduate and nursing personal help.

d. General

The history forms are poor as were the histories taken by the local people. Our personnel should take the history in private. It can be taken by someone other than an examiner, say an undergraduate student. This should be done for two reasons. One, people are not as open with their neighbors; and, we were unable to train these people what we wanted, for example, they would not comprehend what dyspnea is.

The history forms will be revised this fall by me.

The length of our working days should be no longer than 10 hours. This is actual working time, not the advertized working hours. It is quite interesting for me to note that on the days we worked eight hours and I saw 12 patients I saw many sick people. But on the days when I saw 25 patients, they were quite well. William Dow never grasped the significance of this fact, e.g. in Sneedville on Friday of that week at 11:15 he said, "We saw 293 people--a new record. Saw a lot of pathology" Bull! we were too tired to see "a lot of pathology."

Our method of recording results of physical examinations was not uniform or adequate. Examiners should record if follow-up is necessary and list all pathology. This is partly the fault of our forms, partly the fatigue and partly people not caring. We can correct the first two but the third is purely a motivational factor.

We had much friction between the mobile unit personnel and the follow-up workers. They were all set to work 18 hours a day (note: for only one week). Each follow-up should spend at least one week with the mobile unit before the mobile unit arrives at their locality. This would eliminate much of the above mentioned friction.

I have mixed emotions about living in the homes of the community people. On the one hand, it is good for both the communities and for our understanding of the community. But on the other hand, if we arrive at 11PM how much interaction will be and how much sleep and private time will there be. I do not know how to resolve this.

My assignment of each type of personnel is as follows:

1. Upcoming senior medical students--adult physical examinations and chart review.

2. Upcoming juniors - pediatric examinations and follow-up.

3. Upcoming sophomores - follow-up (under the supervision of a junior), pediatric examinations (again under close supervision) and ancillary functions, i.e. ECG, x-ray, blood drawing

4. Nurses - pediatric examinations, follow-up, and nurses usual functions, e.g. immunizations, blood drawing, chaperoning and specimen collecting.

5. Undergraduate - history taking, blood pressure taking, bookkeeping, registration, and community relations (function of our follow-up workers now)

6. Law students - legal counseling with the mobile unit only (two would be sufficient)

7. Local personnel - height and weight, eye check, urinalysis, helping with blood collection and typing.

Personal Evaluation
Tod L'Hommedieu

EVALUATION OF THE MOBILE HEALTH UNIT

PROCESSING OF PATIENTS - NUMBERS

It is interesting to note that the excellent TVA laboratory technicians told us that the daily flow through the complete trailer would be 40 people per day. This was indeed true if: 1) All exams included in the mobile unit were done, 2) Outside station for some of the exams were not developed.

An undergraduate student* working on the trailer was able to identify the "bottle necks" on the van as the audiology station and the computer EKG machine. To speed up processing, EKG machines were set up outside the mobile van. Since these were not capable of being computer processed, they had to be read by a cardiologist, Dr. Battersby. The audiology exam was eliminated as a routine exam, but was available as indicated. This eliminated some borderline cases from being identified.

These two changes tripled the flow rate with little loss of quality of work as far as the laboratory exams were concerned.

PERSONNEL

Undergraduate. Training of undergraduates (non-nursing) involved the following: 1) Drawing of blood; 2) Clerk, filing; 3) X-ray technician, 4) EKG technicians. Undergraduates proved capable in the above assignments.

Residents. These people were utilized to moniter general flow through the unit, history taking, blood pressure, height and weight, and urine examination. One major problem was in taking blood pressures, especially in pediatric patients. The second was in history taking. The questions were limited to yes and no answers and were general in nature. Major responsibility was left with the medical student to repeat pertinent histories.

PHYSICAL PLANT

The mobile unit was a self-contained diagnostic medical unit. Its physical plant consisted of two air-conditioned metal trailers containing the following:

1. X-ray equipment. This equipment was designed to take 4" x 4" chest films at the distance of 40 inches.
2. EKG machine. This machine is designed to have its output processed by a computer.

* John Sperry

3. Tonometry. Screening capability for glaucome.
4. Audiology.
5. Laboratory. Blood processing laboratory for SMA-7, SMA-12, and VDRL. Blood was drawn and prepared for shipping to TVA laboratory here.
6. Examining Rooms. Two designed examining rooms were available in one trailer, with provisions for a third under extreme conditions.
7. Secretarial space for two typists and filing cabinet.

On location, the mobile team adapted local physical facilities examining rooms, EKG stations, height and weight measurements, blood pressure, Snellen eye exams, and legal aid.

The permanent staff of the mobile unit consisted of eight medical students, two law students, two clerk typists, one file clerk, two "EKG technicians", and one x-ray technician, and Dr. Joe Moss. Visiting doctors, medical students, nurses, undergraduate personnel as well as members of community groups were used as available.

Processing of a Patient

The flow of patients through the mobile unit varied depending on local physical facilities and patient load at a given time, but it generally ran as follows:

1. Registration and history taking. By residents under the supervision of a file clerk.
2. Height and weight. Local resident.
3. Eye exam. Snellen chart. Students, nurses or local residents.
4. Urine. Specific gravity, labstix test (glucose, protein) were done by local residents trained by medical students on all urines positi for protein, or when the history was considered suggestive of kidney or bladder disease.
5. Blood pressure. Local residents.
6. The following order was interchangeable:
   a. Blood tests. (Nurses, undergraduates, technicians).
      1. Under two years of age. Finger stick pcv.
      2. Age two to ten years. SMA-7.
      3. Age 10 to fourteen years. SMA-7, SMA-12.
      4. Over age 14. SMA-7, SMA-12, Serology.
   b. EKG. for all age 35 or over, or when indicated in younger persons. (undergraduate)
   c. Chest X-ray. All over age 21. (by technician)
   d. Physical exams. (Nurses, Medical Students, visiting physicians.)
   e. Tonometry. (TVA technician)

f. Immunization. (Nurse, nursing student)
g. Pulmonary function tests as indicated. (undergraduates)

The pediatric flow was different, with very few children needing x-rays or EKGs. For the children, blood work and immunizations were done after the physical exam. Anal tape samples or specimens for worms were taken when history or physical indicated.

As mentioned before the limiting factors of flow in the mobile van were EKG's and audiology. The audiology exam was eliminated, and EKG machines were set up off of the mobile van. With these modifications the mobile van could process 14 to 16 people per hour.

Processing of a Patient's Data

At registration each patient received a folder with his name and serial number on it. His records of physical exam, medical history, and registration information remained in this folder. Blood work, EKG's, and x-rays were sent off for processing. About one week after the exam all reports were returned and placed in the folder. Medical students and the consulting physicians reviewed the records and made recommendations for the follow up team. Copies of these were sent to the patient's physician or Health Department.

Personnel Problems - Local residents.

1. Blood Pressure. Local residents could not be adequately trained to take blood pressures in one day.

2. History Taking. Limitations are obvious, but were a function of time and facilities.

Nursing

The undergraduate nurses became competant pediatric examiners under the instruction of Dr. Moss and medical students..

The possibility of nurses doing exams on adults was explored with variable results. The necessary emphasis on history as well as multi-system pathology entails more training than was usually possible to provide.

Medical Students

Medical Students in the project had completed their first, second or third year. Generally, they could be divided into those who had completed a formal course in physical diagnosis and those who had not. Those who had completed physical diagnosis were capable of doing adequate physical exams, while those who had not completed physical diagnosis were not uniformly capable.

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General

The largest problem, and the problem left unsolved, during the summer was that of excessive patient load, especially adult patients. Pediatric patients presented fewer problems with their straightforward complaints, and simple histories. The chronically ill patients seen by the medical students were complex, and adequate evaluation to determine whether or not referral was necessary took much more time. The frequent overload of adult patients made it necessary for medical students to see 18 to 25 patients in a 10 to 14 hour day. Some of these patients had not seen doctors for 40 years, some never. As the patient load increased, the supervising physicians (from Vanderbilt or locally) whose job was to teach, supervise, and verify physical and historical findings, were utilized as primary examiners. The medical student, initially, just overworked, was thus deprived of supervision.

This resulted in the following:

1. The quality of the physical examinations decreased.
2. The quality of the students write up decreased, making follow-up more difficult.
3. The supervision and teaching of the student decreased.
4. The amount of illness detected as a result of the history and physical exam decreased, as the number of patients increased.
5. The amount of time each patient spent with the medical unit as well as the amount of personal contact between student and patient decreased.

All this resulted in poorer medical care that the students were capable of giving, poor relationships between the patient and student, inadequate teaching by the "supervising physicians", and, most importantly, it prevented the mobile health team from learning about and understanding their patients and the community they were working in.

The following preliminary data will illustrate the consequences of large patient loads. A second year medical student saw 12 patients on a Wednesday while working from 9:00 A. M. to 6:00 P. M. On Friday of the same week working from 9:00 A. M. to 8:00 P. M. this same medical student saw 27 patients.

The results are as follows:

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Patients	No Follow Up	Follow Up Based on Physical Exam	Follow up Lab	X-ray
12	7	4 (pneumocenosis, murmur, hbp, hernia	blood, glucose	
27	18	3 (hernia, hydrocele, BPH)	3	3

It is interesting to note that though the number of patients more than tripled, the amount of physical findings requiring follow up decreased relatively and absolutely.

The end result of poor exams and poor write ups became apparent when evaluation of a patient's chart took place, usually a week after he was seen in the mobile health clinic. Some examples: blood pressures that were high, but only taken once; abdominal and breast masses felt by medical students, but not checked by doctors, and slightly elevated blood glucose with no note of the time of the last meal. Many of these findings would have taken one extra minute on the day of examination to confirm, but now follow up people had to make time consuming home visits. In many cases nothing was done at all. Also significant is the fact that less illness was found as a result of hurried histories and physical exams. The 96% of diagnoses usually made by this means fell to less than 30%, and seemed to be lowest when the most people were seen.

Personal Evaluation

John B. Sperry, Jr

Inasmuch as my work has been limited to the TVA laboratory-trailer, I feel that I should remain within that spectrum of thought. I might, also, add that I have imposed this constraint voluntarily for two reasons:

1. It was my feeling that in order to obtain top efficiency, a set group should specialize on the unit.

2. I believed, throughout the program, that I could learn a great deal about discipline and human nature under Jim Pulliam and Larry Napier.

The key to our success on the trailer (and I have no reservations about using the term "success") was our specialization. Only through repetition, could this degree of efficiency been obtained. Moreover, this specialization was possible because of the instruction given by Jim and Larry. Instruction is a very loose term to define their efforts. Often, they bailed us out by drawing blood or doing EKG's with uncanny speed. Jim also made a point of protecting our interests. Few students doing physicals understood the amount of post-patient work going on in the trailer. During most of the summer, we were the last to finish. Once we started to do lab work on females prior to their physicals, the hours became shorter. Neither did this lengthen anyone else's hours. The point: We could process a female patient in about five minutes, which was the time she would normally spend waiting for a physical. This procedure of channeling patients directly into the lab improved the overall continuity of patient flow. The patient spent less time waiting and was finished earlier. No one likes to wait, and this procedure enhanced our service and efficiency.

As far as running an efficient lab one point is essential. That is, all members of the trailer should share in the responsibility of getting a patient through. Each member should be able to handle each part of the operation. If the clerk is out, another individual should be ready to fill out forms, just as a clerk should be prepared to take x-rays. This was our one big oversight. Each of us had the feeling, this is my job, but not that one.

With the summer coming to an end, it is easy to overlook those first weeks of orientation in Nashville. Only through an improved orientation can those hectic weeks of Murfreesboro and Smithville be avoided. The term most often used during orientation was "flexible." This flexibility became a reality as many

as many nonmedical people became technicians. This required on-the-job orientations, causing long hours and far too few patients for the time expended. Members of the technical group should have had an opportunity to practice and gain some kind of working knowledge before going on the road. I realize that it is easy to bring this point up in retrospect. The practice which would have been essential to alleviating the problem of Murfreesboro is much harder to accomplish than just instruction. However, just some preliminary instruction would have helped.

Another point which is necessary for a sound orientation: we must recognize that our mission in the mountains cannot be a nebulous, social one. The summer had made it perfectly clear that such a medical endeavor is a great task in and of itself. A desire to supplement it with "building houses" is unreasonable. I think all will agree that the early anticipation of branching out from our medical work was aborted due to the time which just wasn't available.

The great dilemma which faced us all was the issue of how many patients could be handled without sacrificing quality medical care. During our week at Briceville, we found less pathology per patient than in any other town. Of course, we did reach more patients. This is one question which I feel will never be totally answered.

There are a few points I feel should be also brought up. One fact which made Smithville disappointing after Murfreesboro was the needs of the patients. In Smithville, we took care of a lot of people who frankly did not need us. Such people in Murfreesboro (that is, the ones who could afford care) did not even know of our existence. Part of the preparatory work should be to make our program known to those who need it.

One point which disturbed me was the way in which our follow-up people told us how to act, what to do, etc. Such bright suggestions as eating lunch in shifts in Deer Lodge after following such a procedure for 7 weeks can only lead to aggravation. In general, everyone, myself included, were inclined to tell others how to do <u>their</u> job. I am afraid that this evaluation is rather piecemeal in approach. But, in conclusion, a more applicable orientation with a more precise air...is in order for next year. Specialization is essential to obtain efficiency, and a getter understanding of the different facets of the organization should make for more understanding and tolerance for each other's work.

In retrospect, I can feel only proud of the work that we've done. Changes, of course, will have to be made--but this is progress! We've learned of this need from the only possible teacher: experience. I want to express my thanks to everyone for putting up with my complaints all summer long. It was a hell of an endeavor, and it is important that it continue.

Personal Evaluation

John Allison Draper, Jr.

Job: Blood drawing, x-ray, EKG, clerical work, finances

Location: Mobile Unit

Overall, I was quite impressed with the way the mobile unit functioned. I think that at our peak, we achieved about as high a degree of efficiency as a group doing an assembly-line type of work can achieve without becoming "coldly" or "ruthlessly" efficient. (Have you ever had an Army physical?) I am afraid that some individuals attained this "cold" efficiency when badly pressed, but I think that we managed to deal with the people as people most of the time. I think that the equipment was good, but I think that I would look into the worth of the EKG as a screening device since this was always a bottleneck and was also one of the most tedious jobs on the project. I think I would also be very selective about who got a hearing test as this test almost never told the people anything they did not already know and was an extremely frustrating job. I think resupply went very smoothly. I always had what I needed, and I never heard any complaints from anyone else. The supervision for my jobs was excellent, loose enough so as not to be annoying but there when you needed it. My supervision as well as resupply was provided by Jim Pulliam and Larry Napier. I think that the work and advice that these two men contributed was largely responsible for making the project a success.

I think that the mobile unit people functioned extremely well. They met many very trying situations with ingenuity and humor which turned a job which could have easily become drudgery into a very enjoyable experience. I do not think that there were any tensions between professional groups. I do think that the law students felt a little guilty about not being as heavily worked as everyone else, but they frequently helped with jobs outside their area of responsibility. I think that, in the future, the legal services should receive much more publicity.

I believe that the only real tension was on a few occasions between the project leadership and the rank and file. Many people were annoyed by the incredible number of meetings, especially early in the project. I think that most of these meetings were a complete waste of time for most people. Jobs could be assigned more efficiently and more fairly by a roster system that could be taken care of by one meeting a week. I think that the project

leadership did an excellent job of planning the project, but they sometimes failed to show the consideration and courtesies to the mobile unit people which we were constantly reminded to show to the "folks." For example, a leader should under no circumstances be late for a meeting that he has called, especially after a hard day's work. This has a terrible effect on morale.

I think that everyone felt overworked at some point, but that is just part of the game unless it happens consistently and morale and efficiency drop. Schedules on the whole were good, but in the future, follow-up people should be impressed with the fact that there is a world of difference between twelve hours of the type of work they did and twelve hours of the type work we did. I do not think some of them realized this when they made our schedules.

I think that the satellite health fairs are an excellent idea and should be emphasized more in the future.

On the whole, my work was interesting and quite challenging, but I think that there should be as much rotation of jobs as possible. Any job can become monotonous when it is done as frequently as our jobs were done. I think that the people generally got good service.

I thought that the housing situation turned out well. I never stayed with a family. I regret this, but families were not available for the boys when I was in the mood to stay with a family. I thoroughly enjoyed the time I spent living in the trailer and in such places as Braden's Grocery. I think that family housing should be made available to everyone if possible, but I don't think that people should be pressured into staying with families.

I most enjoyed the weeks in Clairfield, White Oak, and Briceville. I really liked the people in those places, and I felt like these were the kind of places that really needed the services that we had to offer. I think that I also liked them because they came closer to my idea of Appalachia than the other places.

If I were planning the mobile unit operations for another summer, I would keep most things as they were. I would still have the first week at a place close to Nashville so that it would be easy to get anything not planned for. I would not go to Smithville again. Instead of spending three weeks in one are (Clairfield, White Oak, and Habersham), I would have one central fair for a week or a week and a half and have several satellite health fairs.

I would have all of the people on the mobile unit trained to do several jobs. This would make it possible to change jobs fairly often to combat monotony. I would also put more emphasis on the training of the volunteer workers. Many of the volunteers did excellent work, but in some places much of their work had to be checked or done over.

The people who impressed me the most this summer were the coal miners that I met in Clairfield and White Oak. I think it is very rare that one finds such a combination of fierce pride and good-natured humor. I think that it was probably men like these that built this country and made it what it is today. It was also refreshing to find middle-aged men whose stomachs did not hang over their belts.

I was sort of flattered by all of the visitors we had. I think it was good for them to see the project in operation, and it was interesting talking to some of them. I did not like them looking over my shoulder while I worked, however. It is nothing against them, it is just the way I am.

I think the most important thing that the project proved was simply that such a project could be carried out. Whether it was worth doing will be proved by the continuing follow-up. I think it proved to Vanderbilt that some people are interested in things outside of academia. It may prove to the local doctors and public health officials interested enough to find out about the project that there are a great many health problems hidden out in the hills. It may prove to the government that its money is better spent by private projects than by goernment agencies.

I think that the biggest question that the project posed for me is: Are there any feasible solutions to the problems in the mountains? I think that a report of the project should be submitted to some journals for publication. These might stimulate some thinking in other circles and perhaps bring about some of these feasible solutions.

I think that by the end of the summer, we had the right percentage of people in each job on the mobile unit. I think that the numbers of people in each job could be increased with the increase going into satellite health fairs.

I think that the future of rural health care delivery depends largely on screening projects such as ours and on things like the nurse practitioner program since I do not see any way of attracting a significant number of doctors to places like the mountains on a permanent basis.

Personal Evaluation

Ann Lovering

Job: Lab unit

As I worked on the mobile unit (lab unit) most of the summer, I will base most of my evaluation on what I feel helped make the unit run efficiently.

1. Having a set number of students on the van who knew how all the van operated helped tremendously. During meals, we could trade jobs around, so one person could eat and not leave the unit at a standstill.

2. Four students are a good number in the van. Four students should be chosen in the beginning of orientation to work on the van, and if possible, during orientation, all four should be trained to operate all equipment on the van. The secretary should learn to use all the equipment on the van (not including blood drawing, if desired by the secretary). There were times this summer when we were bogged down by patients who needed x-ray, pulmonary function, EKG, and blood. During this time, it would have helped exceedingly if the secretary had taken over one of the tests, such as pulmonary function or x-ray, at least until we had seen the bulk of the patients. Four people should be chosen to do this work and trained during orientation, and it should be made clear that they will be expected to do all the jobs on the unit.

3. Orientation should be geared less to the sociological aspect of the mountain people. I feel I learned nothing from orientation about the folks compared to the amount I learned from the folks I lived with. They're people like you and me, and I don't feel I needed such a background in order to understand them or to get along with them.

4. Orientation should last only two weeks. If some of the legal and sociological aspects in orientation were cut out, then more time could be given to training people to give physicals and to work in the lab unit.

5. Somehow (during orientation), emphasize to the follow-up people planning the fairs in the towns that the unit works as efficiently as possible, and only the people working in it know just how things can and can't be done. During the summer several times follow-up people from the town we were in came up to me to tell me what to do during the day. This I strongly resented (and I know there were many others who felt the way I did)

I feel from what I saw, the follow-up people did a good job organizing the fair, but once the unit came to their town, I do not feel it was their job to try to reorganize us.

One of the ways in which my feelings changed over the summer is my attitude to the country doctors. Before the summer started, I had a very negative attitude toward country doctors. Now, at the end of the summer, I cannot help but respect the kind of man who dedicates his life to the people in the mountains. As many patients as he sees per week, I can understand his attempt to get away from it all, for example, by taking every Wednesday off.

I was also not so sure at the beginning of the summer if I'd be glad I decided to take the job instead of a good paying job in D.C. Once again, now that the summer is over, I have a more positive attitude. The experience of living with the folks in itself justified the summer. I enjoyed the challenge of working so hard to see so many folks in towns like Briceville and working in a student organized project made it easier to joke a bit when the pressure was high during a busy day.

Personal Evaluation

Barbara Miesse

Job: Clerk
Location: Mobile Unit

I think the mobile unit functioned surprisingly well even at the start of the summer. Unfortunately, towards the end of the summer it seemed to become rigidly efficient, with certain people continually doing the same jobs. The equipment of the mobile unit was adequate after we recieved the two mobile EKG units. The supplies also were adequate at least from the point of view of my job.

The people on the mobile unit also surprised me. There was little or no tension between professional groups that I could detect. Even in Murfreesboro there was a spirit of teamwork and the people on the mobile unit became very close, which could definitely be a problem from the point of view of all those working with the project but not with the mobile unit. This closeness was a contributing factor to the tensions that developed in some places between the mobile unit people and the follow-up people who came to be considered as outsiders. I think the plan, mentioned at debriefing, of rotating in and out of the mobile unit is a good one, and could possibly solve this problem.

I do not believe that any certain groups felt overworked. The mobile unit people as a whole at times felt overworked. A more persistent problem, however, was the feeling many had that we had no control at all over our working hours or how many people we saw in one day. The mobile unit as a decision making group should have been as unstructured as possible--yet it should have been clear who was in charge of the formal decision of when to cut off people and hours with that person swayed by the wishes of the group. Instead there was a duplication of jobs that was confusing and unnecessary.

Changes in the scheduling of the mobile unit may show to be very awarding next year. There were some communities where a week was not long enough. Although it may be difficult to decide beforehand what communities will require longer, at least those such as Briceville who have shown a magnitude of interest this year can be scheduled for two weeks. Plans should also be made to end one week earlier and perhaps start one week earlier than we did this year in order to give the follow-up people in the last town a chance to complete their work. A way should also

be found to obtain the results of our tests faster. Another possibility in scheduling is a break in the middle of the summer to avoid the progressive stagnation and fatigue that occurred this summer. Satellite health fairs seem to be extremely worth while and could especially have been useful in places like Sneedville where the poor are scattered in small communities outside of town. We would have to obtain more mobile equipment, however, for satellite health fairs to be feasible. My work was very interesting almost all of the time. This was because I was not stuck for long periods of time at one job. I feel that others of non-medical personnel, however, were not so lucky.

From what little I know about medicine, I would say that the people who came to the health fairs got fair to good service. At the first of the summer after the first two or three days people probably got better care since fatigue and stagnation had not set in. But this was not as much a factor in the quality of the care as the number of people seen in one day. People on crowded days received poorer service, especially if overcrowding caused us to run into the evening.

I lived in a home all but one week of the summer and it was an extremely worth while experience. However, I can also see why others in the group preferred not to live in homes. I think that, if possible, better arrangements should be made for those who do not wish to live in homes, than sleeping on the floor of the mobile unit.

The best communities to work in involved two factors. One was the community organization and support backing the health fair. The communities that showed active support and concern were the best to work in. The other factor is the number of people we saw during the week and the need of the people as we saw it for our health care. Too small a number of people or an overwhelming number of people who didn't seem to need our care contributed to not liking one community as much as another.

In basic structure the mobile unit should be much more mobile with possibly a second smaller unit for satellite health fairs. The schedule should also be more flexible. Unfortunately, a lot of good ideas were dropped by the wayside at the first of the summer when we ran short of staff people--such as arts and crafts and movies. These plans should be reinstated next summer with enough personnel to be sure that they get carried out.

As communities the most impressive thing I encountered with the people was their willingness to work hard to bring the health fair into their town. I was even more impressed with the people as individuals. They seem less interested in playing roles and putting up marks than people I had encountered elsewhere. While some were unaware, others seemed to realize and take full advantage of the many blessings of the lives they lead. The people were friendly although at first cautious and almost always willing to pitch in and help.

I think that the dignitaries who were being shown around during the summer were a necessary part of the project. I don't recall having any negative feelings toward them. The project proved a great deal to me about the falsity of the statement that "nothing can be done for these people; they don't want help." I learned how important it was to organize the communities and have them put on the health fairs if you wanted to leave behind lasting results. I think that the project proved to the mountain people that they did have resources and that they could do something with these resources.

The main question that the project has posed is how to get permanent adequate health care (such as the opening of the Jellico Hospital) into the mountains. Progress was made toward answering this question by the establishment of the nurse practitioner program. I cannot, however, predict what the final answer will be. I think this project has brought the question into focus and perhaps provided useful data for answering the question.

I think the data should be distributed to each member of the group. As for pressuring any group with the data I leave that up to the discretion of the medical personnel.

The functions of some groups followed closely the conception of their roles laid down at the first of the summer. Medical personnel especially had a fair idea at the first of the summer what their jobs would entail. Al Draper I am sure did not know what he was in for. Being the accountant took up about 10% of his time, if that much. The role of the follow-up people as community organizers was never clearly understood by the mobile unit people who saw their function as primarily connected with the health fair. As a clerk, I found my job a great deal more varied than I expected, and also a great deal more interesting. The function of the law students with the mobile unit was probably similar to that envisioned at the start of the summer.

The need for additional personnel falls under many categories. There should be more medical students and nurses so that there are

enough medical personnel participating in follow-up. There should be more extraneous personnel with the mobile unit to allow for the medical technician work not requiring medical training and still leave enough people for arts and crafts. The Denver Screening and psychological studies should be continued next year.

In all I found the summer an extremely meaningful and interesting one. Although I did not develop a formula for rural health care delivery, it was easy to see that it is very much needed. The solution of the problem may very well be with projects such as ours in that it was a cooperation of a university with a government agency. Both of these institutions should have a hand in caring for the people of rural communities and perhaps will moreso in the future.

Personal Evaluation

Ronald Massey

Job: Mobile Unit
Location: Mobile Unit

I. Mobile Unit

The TVA mobile units, I feel, were valuable to the project in many ways. Although unable to handle the volume of patients without supplementary equipment, they proved useful as rallying points, as supply depots, as symbols of the health fair, and as supplemental housing. All this was in addition to their function as medical screening units. As mentioned, supplemental equipment, such as EKG machines, auxiliary examining and blood-drawing rooms had to be utilized. In spite of this, I have nothing but praise for the efficiency and flexibility of the TVA personnel involved--even though this work was far from their usual routine.

II. Student Personnel

A. Mobile Unit

The students involved in the mobile unit operations actually belonged to several different groups, both in types of job and level of training. The first of these groups consisted of undergraduate, and recent graduate students with non-medical training. Although originally intended to serve as clerks, typists, recreation supervisors, etc., most ended up serving, at least part time, as medical technicians--drawing blood, running EKG's, taking blood pressures, and so forth. They proved uniformly to be quite good at these tasks. Another group consisted of the student nurses. All the nurses received training in physical diagnosis. After the project was underway, however, it became apparent that some of the nurses were unhappy utilizing those skills, preferring instead to work as nurses. Most of the nurses, to be fair, did enjoy the role of nurse practitioner. Only one nurse, however, was comfortable doing adult physicals--and she only worked up women patients. The other nurses were most at ease doing pediatric physicals. One problem, not anticipated, was that certain of these nurses became so accustomed to the role of examiner that they refused to perform certain nursing tasks, such as mid-stream clean catch urine specimens on female patients when requested to do so by the medical students. This, however, happened only rarely, and then only in the last two weeks of the project.

A third group was the medical students. They had from one to three years of medical training. Those students with only one year of medical school went through a brief course in physical examination. In general, from my biased viewpoint, the medical students performed quite adequately in screening patients. As a learning experience, the job could not be faulted. The only difficulties in that regard were an occasional lack of adequate supervision and a general lack of time to do the desired reading. Since we, along with the law students, were the major group performing the task for which we had actually been trained, we probably had the least trouble adjusting to our task.

The final group was, of course, the law students. In offering legal advice and helping patients to gain needed aid, they proved invaluable. I, for one, would not care to attempt another such project without similar people along.

B. Follow-Up Personnel

The people actually living in the areas we visited and responsible for arranging the health fair and following up after it had gone were likewise of different origins. The work performed by these people was in all cases excellent. The only problems I can remember were due in large part to the lack of contact these people had with the fair before it reached their area and the subsequent failure of the follow-up people to understand certain of the attitudes of the mobile unit people.

C. Interpresonal Relationships

Considering the large size of the group involved, problems between people were few. There was occasional resentment expressed over certain people who did not seem to be sharing their load of the work. However, these resentments were momentary and did not significantly affect relationships between people. Group morale varied from location to location. One interesting thing was the strong group identity which developed and which has, to a certain extent, persisted.

III. Housing

The idea of actually living in the homes of people in the community was a good one and, I feel, should be continued in any future projects. I never did stay "with the folks" on this project, however, preferring to sleep on the mobile units. For those people of a more sociable turn, I feel that the idea is good as it helps the sense of community participation in the project.

IV. Visitors

I include in this category the medical personnel from Vanderbilt and from the local area who visited the project and/or helped in the evaluation of patients. In the beginning, of course, there existed a definite lack of supervisory personnel. Until we acquired a permanent doctor in the person of Joe Moss, Jr., in fact, we could not at times be sure of having a doctor with us. Those doctors from Vanderbilt who came to help were generally very appreciated by the students. There was rarely enough of them, however. Unfortunately, the last week, in Deer Lodge, the problem was the opposite. There were actually at times too many doctors. This created a problem in public relations in that the medical students, myself included, tended to call on certain more familiar, or more available doctors and to avoid those doctors in a position of power, such as Dr. John Chapman. I feel that these doctors should be made aware of the fact that no personal slight was intended. I would ask them, however, where they were earlier in the summer when we needed them.

Those people who came to the project merely to look around were mainly a nuisance. They interfered with the efficiency of the group and sidetracked valuable personnel. I realize, of course, that such a project does not exist in a vacuum and that public relations is vitally important to success.

V. Problems and Suggestions

In addition to the problems already mentioned, there are certain others that should be noted. One was the inadequacy of the makeshift equipment required by our lack of funds. In this, I particularly am thinking of the sheets used as partitions between examining rooms. Not only were these difficult to hang in some of the buildings utilized but they also were inadequate in terms of privacy. They also were the most time consuming item in setting up in a new location. I feel some form of rigid divider is a necessity.

Another problem was the constant and heavy work load faced by everyone. Not only did this not leave time for study but it also created problems in terms of morale and in terms of willingness of mobile unit personnel to help in follow-up. After spending nine hours working up patients, one does not feel at all like reviewing charts done in previous weeks. I definitely feel some alteration and variety in work load is necessary.

VI. Conclusions

I do not feel qualified to comment on the effects of our project on such things as rural health care or nurse practitioner

programs. However, I would like to relate that most of our patients this summer were pleased with the health fairs. Many explained that the time taken to go through the project (several hours) was no longer than they would have to wait in the office of one of the overworked local doctors. In addition, they were pleased at the thoroughness of our examinations and at the fact that we were willing to listen to them. In that regard, we saw many patients who were under monthly or weekly doctor care, whom we did not need to see, but who were very pleased with the health fair.

One item I failed to mention is the help given to us by Vanderbilt in terms of both equipment, personnel, and services. We all have tended to forget this help in light of some of the other problems we had with the University. Nonetheless, without the school's help, the project would not have been possible.

Personal Evaluation

Linda Bell

Considering the limited experience all of us had at the beginning of the summer, the work the mobile unit people did during the various community Health Fairs was amazingly well organized and efficient. This being a new learning experience, the unit had many loop-holes of inefficiency. The important thing was that each problem was apparent and we, as a group, tried to correct these in the most efficient way. Of course, here it is necessary to compare the operation at the beginning in Murfreesboro and Smithville to the last community in Deer Lodge. Through the summer the unit as a whole grew into an increasingly more efficient organization. Perhaps at a point too we fell into specific jobs and stayed at those continually. In the first few weeks the unit and its operation was new to everyone and with many different things to do most of us wanted to learn, or at least try, everything. Therefore, jobs were changing every few days and this created some confusion and inefficiency. But, I also want to say that it was the best way to do it. The enthusiasm to learn and experiment kept the morale of the group high.

Fortunately, with help from many people, equipment and supplies presented little problem. The difficulty was that someone needed to keep watch on what was getting low so that the things could be gotten in time. One area in which I helped some, immunizations, made me realize that projecting what we'll need and getting the supplies requires a bit of time. This is an area in which someone needs to accept the responsibility to see that the supplies of all kinds are well stocked. More organization and uniformity is necessary for the storing of supplies--that will not only simplify the job of stocking the equipment, but everyone will know where things are kept.

The biggest problem the entire summer was the lack of supervision. Having one doctor working with us was a great asset; and being a pediatrician, the pediatrics area was well supervised and problems were handled in the context of the community resources and past experiences. We had great help all summer from visiting doctors, but if they haven't been working in similar circumstances it is difficult to evaluate a problem and how it should be followed. Therefore, I see a necessity for at least two doctors--one in pediatrics area, and one in adult area. This in conjunction with visiting doctors would alleviate many problems and confusion. I think it is important to bring as many doctors in contact with the project and that when they are there to utilize their talents. This will hopefully simulate interest and enthusiasm on the part of both doctors and student.

We were fortunate that although we had a large group working closely and intensely for the whole summer, everyone on the unit got along well. There were few apparent personality conflicts and most everyone was considerate of the work all the others were doing. We worked together effectively as a team. Medical and non-medical people worked together well, because everyone was willing to take time to explain things to the others. Because of this and the ability to solve rising problems, each individual progressed to a level of knowledge and efficiency which helped to make the Health Fairs run smoothly. Many times people felt that the load was too heavy and long and that their work was becoming haphazard. Having little time of our own made it more difficult to keep going. The schedule needs to be more regulated, but this should be done in such a way that the community is setting the hours, not us. Then if a situation arises that we have to work long hours it is an exception rather than everyday. We had a small problem with people getting a good weekend break...this summer working on Saturday made for a long, hard week with very little time to relax because on Sunday we needed to move to a new community and get set up for another week. I think that maybe this will work itself out with the possibilities of modifying the procedure and staying longer in one place.

An interesting sidelight for the mobile unit was the satellite clinics that were held. We were able to see a good number of people in one day that did not or could not get into the Health Fair. It gave us a chance to reach some of the smaller communities in the valley and hopefully it would act as a catalyst for future Health care in their area.

Working on the unit was the most exciting and interesting learning experience I have had. In the beginning I had not planned on working with the unit. However, when the unit was in Murfreesboro, I was helping out everyday and just learning tons of things and everybody was so patient and helpful in teaching and explaing things to me, I decided this experience could not end after a week. So things were arranged and I travelled with the unit to various communities the entire summer. The work was challenging and I had great fun learning.

The medical learning was only a part of the experience this summer, because I learned equally as much from community and the families I lived with during the week. Seeing and living the way these folks lived (without the luxuries I was used to) was indeed an experience. Their slow, easy going pace was good to see and most families were happy. They welcomed me with the best they had and tried hard to make me feel at home. I was with a peaceful happiness inside. I grew fond of many kids who all were different,

but all full of life and curiousity. Perhaps this was a more important experience than any other. We were given a chance to really get to know how the folks in the mountains live. I think in future projects arrangements should continue to be made for the mobile unit people to live with families, because it is rewarding in every way.

Living with a family gave me an idea of what these communities were working for and to realize how important it was to them. Because despite what type of facilities were available, the communities that were most pleasant to work in were those where the community people were fired up to help in any way. They worked as hard as the mobile unit people and the best thing was that we worked together as one big team. This made me feel that it was actually the community giving the Health Fair and we were there to help them in any way we could. I was impressed with the determination of some of these people to bring better health care to their communities.

Many people visited the Health Fairs this summer and on the whole it was a good thing. Naturally, I was more impressed with and got to know better those doctors which stayed and worked with us. I feel they have to spend more time around the people before a true understanding of the situation can be obtained. I recall that oftentimes when people were being ushered around I felt ill at ease. This was probably due to a lack of self confidence but also I had a feeling that those looking and not doing were trying to find things to criticize. Perhaps this was a misconception on my part, but in the future stress should be made on assisting rather than observing.

This project has shown two things to me; one is that there is a real need to build a proper health care system in rural areas; two, is although I've often thought about working with poorer people in rural areas, I was never sure of how I was going to do it or if I really wanted to--this summer proved to me I did. I would also hope that this project showed the need to the community people and other public that a health care delivery system is badly needed. The data we have received from project should be made available to those interested. This information should be incorporated into future transactions with anybody.

There were various groups making up the whole, each with some form of function. All those working on the mobile unit functioned together for the same goal, to run an efficient and thorough screening. The nurses and medical students played the primary role of physical screening, while the others did equally important tests. The follow-up people played an extremely important role working

with the community folks. They helped in any way to create enthusiasm for a health council and trying to develop better health care delivery in their area. This was most important because this is what would be left after the mobile unit left. This is such an important role that everyone should have the opportunity to do follow-up and visit some folks in their homes.

There is undoubtedly a great need in the rural areas to improve the health care delivery system. The doctors need to open their doors more freely, but more important more doctors need to come in. As many of the communities this summer have done, clinics are being started and staffed once a week by a visiting doctor and otherwise by a nurse. Then the availability of a hospital should work such that a community could create enough interest to doctors from the nearest one, or at least help in admitting of patients from the rural community clinics. This way the folks from the community are drawn into better health care and doctors are seeing and becoming more aware of needs of these folks.

Personal Evaluation

Charles Suggs

There are many factors to the project this summer, and one does not know quite where to begin. First of all I suppose that I would give my personal praise before anything else. That would only be natural. I enjoyed myself very much after getting off to a slow start, one from jumping into the midst of a group of people that had been working for a while together and were rolling along at a good pace when I arrived. In those two weeks I had for orientation, the best for me would have been some individual training in giving the physical exam since I had missed the organized lecture approach the others had. Consequently, I was always behind and even when we started in Murfreesboro. Not having my feet on the ground and still feeling my way around in a new and strange environment, I did not feel in a position in any way to ask for the kind of training I needed. What complicated the situation from my own position was that I did not know what was the best approach to the matter; therefore, I was doing about three things at once. Nonetheless, all things worked out in the end, and I really cannot complain. However, there was the educational opportunity for the summer that seemed to be in the wind during the orientation, but never was it realized. That can partly be rationalized from the standpoint that the whole project was a first for everyone and not all the dreams are going to be realized. That is always true whenever an undertaking such as ours especially for the first time. In another go around the educational aspects definitely need to be included. If more money is granted for next year to allow for more medical personnel (particularly medical students), then some time schedule could be arranged to allow for studying and learning. One idea as expressed by Pat Maxwell is that on different weeks the student go on follow-up work in a fashion that hours are assured for academic pursuits. Guidance in the field will definitely be needed, as I would be looking for some as to what to read in order to find out what I am looking for, and what books might suit my purposes when the point of my training is considered. I know that I would have gained much more from the situation I was in medically if I had been able to do research. I would have understood and known a lot of whys and therefores, that I do not understand presently and will have to hope that my memory is excellent at the proper times in the next year. I shall have to admit that I may have learned a lot more than I realize and shall only do so when I get into physical diagnosis next spring. After the year, then I should make an appraisal. However, I am leaving with a deficit that I would not like to have.

Equipment

The only piece of equipment that we absolutely needed was the x-ray machine. Of course, that statement needs substantial qualification. Providing that we had enough room to do all the test and related aspects of the silver and white vans, we could do without them both with the exception of the x-ray. Naturally, there are problems that I would not want to cope with. For instance, in Clairfield and White Oak there was definitely not enough room to do everything without the aid of the two vans. There would be problems if we had to rely solely on local facilities, for I do not believe that we could ever count on enough space in the proper arrangements to do away with any type of mobile unit. Therefore, the discussion turns as to what type of mobile unit would be satisfactory for us. The white van was good, but not used as well as it could have been. Some type of mobile unit that has three or four examining rooms would be great in that (assuming there is more personnel in the future) it would free us from so much dependency upon local facilities. Work that did not demand such particular arrangements would be able to float easier. Such as blood processing, immunization (adult), registration (or typing patients forms) and chart processing. The van with four rooms has no waiting room; the one with three has one. Storage of equipment and supplies needs to be refined, in that things tended to be too spread out. This is one aspect that I am not too sure can be improved considering most of the circumstances we will be working in do not permit what is in all practical terms a storeroom for everything, or nearly everything. Examining rooms need to some extent be able to store what may be needed there. One thing that should be avoided is what existed in regards to the front examining room on the white van. That is too much was stored in there that was used a lot, and much time was lost waiting outside in order to get an item, or the examiner was interrupted too often during an exam to hand out supplies through the doorway. Although no one thought of it, the supplies in that room probably should have switched with those in the middle room which was open considerably more often.

The middle room was abominal in regards to its function as an examining room, besides it was a lot of wasted space--wasted for our purposes. I think that after a while people finally knew how I felt about it, and no longer was asked to work in it. Besides for me personally it was a physical hardship to work in that room. Quite obviously.

I know that there are ideas floating around for types of mobile units for next year. As an adjunct to the opening statement of this section, a mobile unit with an x-ray is absolutely necessary. Whatever space is available perhaps could be used for tests

that were conducted in the silver unit this summer. Blood processing somehow is not required to be in the unit, but as far as having all of those supplies right there and not scattered about certainly simplified matters somewhat. Of course, there was limited space there, and only a few could effectively work there even when the loads were heavy.

If satellite units are established then the question of blood processing and x-ray must be tackled and solved. I believe that a centrifuge was taken for those this year and that was no problem. Somehow I do not like the idea of setting up the satellite clinics without assuring that everyone receives the same tests and treatment that those at the main health fair are receiving. The essence of what I am saying is can we get two x-ray machines or assure a means of those people that they get a chest film without a lot of undue trouble? Certainly if we have several mobile examining units then we shall be less dependent upon local facilities. Naturally, the units need to be self-sufficient with the ability to hook up to local power supplies and water or else to have a water tank that will suffice for a day and then have a means to refill the tank. I hope that if a satellite clinic is set up that the unit is mobile enough that one day stops are rather feasible, because there is a lot of work in setting up any mobile unit as well as making it ready for travel. Without a water supply, then a transit water stop will have to be made. Also for the unit that has the refrigerator(s), then the minimal amount of travel time must be planned so as to maximize the coolness in the refrigerator especially in regard to the culture mediums and the frozen polio vaccines.

Although there was no critical shortage, a greater number of sheets and gowns should be secured for next summer, particularly sheets. There should be enough to block off adequately rooms for pediatrics and more privacy should be offered. Just because they are children does not mean that they have to be given considerable less than adults. Only on a few occasions did a problem arise with regard to privacy in the adult examining rooms. Many of my female patients were obviously uneasy, not from the fact that they were being modest naturally and not accustomed to being seen by a doctor but were uncomfortable because of the openess that existed even with all the closeness of the compartments in Deer Lodge. It must be realized and taken into consideration that my examining room was nearest the door, and at times I too was uneasy for my patient due to the closeness of that door and the loudness of chatter and goings on that made one feel that the open public was just outside and invading the kind of privacy that is due a doctor and his patient. I realize that degree of privacy is never going to exist

under the conditions that we shall be working, but nonetheless, I would like to see an effort to improve the situation. For then I have less difficulty is putting my patients at ease and have to use less time in questioning and examining them.

Supplies

To me most of the organization of supplies was poorly done. The only exception was the silver unit where Jim generally had everything under control. In the beginning, even he underestimated the demand, but the situation was soon rectified. I first want to admit the difficulty in estimating the numbers for any one location and for any breakdown thereof. Estimating as related to forecasting. Just about all items ran short at one time or another except for the gloves and phisohex. Some of the girls gave me dirty looks when I suggested counting the number of dosages given of each vaccine in each location and also the total. If there is going to be a project next year and particularly if it is going to be bigger, then it must benecessary to do a better job of forecasting our needs. From the estimation of immunizations there comes the number of vials of each vaccine, number of IM syringes and TB syringes, immunization and health cards, cotton alcohol, band-aides, lancets, capillary tubes, VDRL tubes and slips, other tubes and appropriate slips if we do not have TVA and Jim with us. The blood work and immunizations is a hell of a lot bigger than almost anyone realized. Having worked somewhat on both ends I realized and partly contributed to some of the sloppy work that frequently occurred. One aim that I have is to see that blood becomes more efficient than what it was. To some extent I cannot critize because of the number of people we saw on some days. But samples were not collected for reasons not understood, and somehow a check needs to be instituted to make sure that fewer people leave the fair with incomplete charts. Also samples had to be thrown out from mislabeling all along the line from collection through processing. This was due to carelessness that many people were guilty of, including myself, and this is partially understandable, but intolerable, and hard to correct. While doing charts of normals at Sneedville as part of my follow-up duties, I was amazed at the number of people who did not have any blood work at all. This is why I would like some check to be instituted next year.

As part of the organization of this part, the people from whom we will be getting supplies need to know far in advance of our need in order to supply us. Nobody has the quantities that we devour just standing on hand as a rule. So if the health department is furnishing us with syringes, for example, then by

next March or early April they need to be told that we need 6,000 IM syringes. This way there is plenty of time for ordering and delivery, and partial distribution to some of the areas that we will be visiting. Of course, we will keep some with us so that we shall not have to live from one week to the next. There is also the assumption that there is constant pressure kept on those who are supposed to be getting those items for us.

Depending how supply matters are organized will directly reflect on our total capacity to store all items. It is senseless to start out carrying everything to be consumed for the entire duration of the health fairs, but at the same time items such as blood agar plates, plastic speculums, tongue blades, band-aides, etc., that were not received from the health department, but from Vanderbilt usually, really ought to be on hand in the beginning but stored somewhere from which delivery is not much of a problem. One idea that could be investigated is to distribute supplies such as these to health departments that will be working with us. Another consideration is that in planning on some kind of timetable, one should not use the end of the week for a cut off for any kind of time unit, but a Monday or a Tuesday. This way hopefully supplies will be sufficient to start Monday morning and preferably the whole day depending on how far away the health department is and time used in going for a pick-up and returning. If we supply our own styrofoam cups and lids next time, then the quantities thought of should be at least one box of one thousand cups and lids per week plus an additional box of one thousand every three to four weeks. The additional amount is because in some areas we saw more than 1000 people (not all of whom used a urine cup) and the cups are never used in a one to one relationship as well as being used for other purposes and some being wasted. Unfortunately waste always occurs, but is a very important part of an estimation; it alone can blow someone's fine job of estimation and play havock if it is totally ignored.

I hope some serious consideration is given as to how to revamp supplies. Generally it seemed to be a mild headache somewhat continously throughout the summer. Just from this point of view--some kind of mobile unit is necessary unless a truck with shelves and cabinets built for travelling with refrigerators for vaccines and bacteriology supplies is found. The white van for the most part did a fine job with the exceptions mentioned earlier in Equipment. If we have one or two mobile units next year similar to the white van, then I would like to see, if reconstruction is possible, to have one room be a storage room. If supplies is as well organized as I hope it to be, then one person needs to run the show

in order to keep tab on all the supplies, rate of use, and perhaps this would cut down on some waste. Refrigerators that are slightly larger than those in the silver and white units would be best I think in regard to ease of moving as well as loading and unloading from the units. Quantity needed would be one at least if not two again depending on how much needs to be and is kept on hand. With good programming and weekly pick-ups one should do the job providing it is larger than this summer's.

Records

This is a massive area and one of importance. After the fair had been going on for two or three weeks, then the charts started being completed with all the test data returned. Then the evaluation of those charts began. At times there were only a few doing them and doing it most of the time while the less experienced medical students continued to do physical exams. For brute efficiency this was probably the best, but not the best for all concerned in regard to learning after the charts of those they examined and to learn from other cases who had interesting pathology. Since we are all students and should be concerned with continuing education, then somehow charts should be brought into the picture. Maybe after the charts have been evaluated, then a number can be selected and someone who has more knowledge, be it a fourth year student or one of the physicians with us, can present the charts to the medical group. There is a lot to be learned from them. One suggestion to me was to make a list and then when the charts are completed see how the physical exam sta cked up with the clinical data. That is good, but very limited as a teaching tool. As far as asking questions, sometimes it was as bad as pulling teeth, for some individuals were reluctant to give time from the position of a teacher. This might be discussed in more detail in the personnel section.

Most of the data was returned within a reasonable amount of time, and so there is not much to adjust there. There is one matter that does need improving and that is the return on PAP smears. If nothing can be worked out for a faster return on all, then a priority needs to be established. Within this set-up, the medical examiner may see from the history and exam that the Pap is indeed important to complete the woman's chart prior to making a first go around judgment on the status of that individual. The priority smears would be mailed out first thing each morning and have it agreed upon by the receiving doctor and cytologist to give those smears priority and return the reports in a few days so that

we don't have to wait nearly as long as we did this summer, which was ridiculous for some cases in my opinion. This is a definite area of needed improvement.

Personnel

For having dropped into the midst of the group on Monday, June 8, I believe that I got along with everyone quite well for that and not knowing anyone except Anne Lovering. I don't have any complaints as not really getting along with anyone. Coming in as I did naturally presents some problems just from the circumstances alone. Even though lots of people told me that most everyone knew few if any prior to the beginning of the project, that was not evident to me since they had already gotten acquainted with most everyone by the time I arrived. I over a period of time got to know faces and names and became somewhat familiar with everyone, but from discussions I foun d that I was not the only one who at different times felt as if he were not really a part of the group. Even within the mobile unit there were clics of sort, but were flexible with some people flowing from one to another. Perhaps I felt the way I did more oftener than others, because I was not a member of any clic. At times I did not mind, because it allowed me to accomplish chores that may not have been done otherwise or prevent delays in the unit's operations that few people were aware of. Of course, one of the drawbacks is that it took longer to feel in the groove, if I ever did. Many times I loaded other people's stuff and drove off by myself for the next destination with other cars loaded and an empty front seat in mine. The frequency of such an event was enough to make me think. This, however, is a personal gripe and has been heard before; therefore, it doesn't need to be hashed over any longer.

Before I begin to mention any names in particular, I must first admit that I am sure there are some who have good gripes about me, but I am unaware of them. In a way I wish I knew of some of them. Feedback is necessary. I imagine that others felt as I did, not really in a position to go up to a person and tell that he was lazy and get to work or quit doing a half-ass job, which it may appeared to me in my own eyes. I don't want to picture myself in a holier than thou position, one which someone is bound to suggest. Hopefully no one will misunderstand my remarks. Ron Massey and I in the latter two weeks of the fair realized that we were consistently finishing almost last, and by an appreciable amount of time. In a way we did not mind, because we both know that the work had to be done and the people were going to be seen. We also knew that it would be a lot easier to keep quiet and do it ourselves than to attempt to get someone

else to do it. I do not want to imply that it was never done, because I have myself asked as a favor some of the people who have tended to relax and let others finish up and they have done as I have requested. Sometimes they have grumbled, but they did it, but at times I have had severe reservations as to the quality of that person's performance. People have accused me of running around unnecessarily, and I suppose on occasion that it may have been true, but there were those who seemed to me to do more than was justified. I have gripes about this of Rick Davidson and Jean Austin. I have heard even Henry Unger make comments about how he refused to work on the white van examining men if Rick were to be the other examiner, because of Rick's frequent wanderings, many of which were questioned as to their necessity. On one occasion, Tony and I were working out there and I had to do some running about for supplies or to get something straightened out, and Tony worked for at least half an hour or more by himself without complaining of being alone. It was something I appreciated greatly.

One criticism of me that has come to mind is that I was too slow in giving a physical. Not having any physical diagnosis course and being less knowledgeable than my closest comparable--Tony--I am not sure how justified the remarks are both for and against my speed. My main two criteria were hitting every aspect important in our screening exams and being thorough. Times when I missed cases of emphysema and tuberculosis caused me to question the accurateness of my exams overall and was an impetus for me to do better. Whenever there was a personal choice between quality and quantity, it was almost always quality.

I should say that when we had lots of people to see and they were standing out in the halls to be seen, then everyone worked hard. I cannot say that no one did not work hard, for everyone did. It is just that some worked harder. However, when it came to getting the little things accomplished I was bothered by the amount of apathy that at times was manifested. Naturally the same few people looked after the Pap smears, straightening the rooms out at the end of the day or restocking the rooms with some of the supplies. It just seemed that some did not care, and would only secure supplies that they themselves needed. This may seem that on all occasions some did the work and some did not. That was not always the case, but when things were set up on Sunday there was more of a communal effort than at many other times. I suppose that some may think that I did not work on Sunday, and it may well be true and gripes justified. I knew for one thing that I worked during the week and that may not always be true for some of the others. Somehow I don't seem to be getting down in words what thoughts I have had over the past few weeks.

All throughout the summer we all discussed quality vs. quantity. Well now I am rather convinced that quality definitely takes the preference over quantity, but I am not sure yet how the two should be adjusted to one another. This judgment was solidified in doing charts and follow-up. I did an EKG at the Hancock County Hospital on one patient who had a heart attack 1½ years ago and from history perhaps one last March. The second possible attack was not brought out in the PE and somehow this woman escaped both EKG and blood work at the fair. It is this type of sloppy work that I am most bothered about. Lots of people missed blood work; I realize that a number of people come wishing only blood work and some who refuse to have it. Somehow we need to think of a way to convince these individuals that is necessary for them to have it in order to complete our findings on them as well as their physical screening. This is a thing I really like to crack down on.

The week in Sneedville, I had an occasion to hear Tod make the comment that he had just done three physicals in 15 minutes. At the time I was deeply disturbed as to the quality of the examinations they received. I am no less disturbed now, but how was I going to tell Tod or those people that one did a sloppy job and the others that they perhaps did not actually receive a physical as they might have believed. For me that one example was rather contradictory to Tod's arguments for quality over quantity. I must admit that I do not know the particulars in the case, and maybe a five minute physical was satisfactory for each of these men. Somehow I doubt it. Maybe I am too ideal or expect too much from people; in something as this project I expect that everyone will be a stickler for details as I am or tend to be. Most of the time I do not mind some of the extra duty that I voluntarily give myself for the good of the project, but after eight weeks it does begin to become a little tiring carrying the ball. Maybe then I am more giving to the commune than most people as far as giving time and energy.

In regard to giving to the commune, I do have a gripe. It appeared that a number of members in the group did not mind asking me to give of myself either to the project or to them, but somehow the reverse situation went frustrated frequently. I know that for myself there will never be a 1:1 correspondence, but something different. Over a period of time, I do grow of the imbalance, particularly if it seems to be going one way or is way out of proportion. Again this is mainly a personal gripe, but in a way it is not. Many times I have bought food for myself, and sometimes some have thought that I should share with everyone, particularly them. This would be fine if those same people would do the same, but it doesn't seem to occur. Maybe they never think about it. Perhaps it is because I give the impression of being nice and

accommodating; well most of the time I suppose I am, but things do go too far and I do not know how to say no and draw the line so as not to offend people giving them the impression that I am a bastard. For this reason I at times hesitate doing things that involve money, afraid that I shall get on the short end of the deal for many times in the past I have taken a loss. Again it is a personal problem and should not be a major part of this report.

Complaints along this line did surface now as I do a bit of reflection. At one or two meetings someone asked that people only consume their own food and not take the liberty to help themselves to someone else's supplies without asking. I can easily sympathize for I have much experience along this line. This is a hard problem to solve, but at intervals someone ought to mention that each should respect the property of others, because such acts do damage to the internal structure of the group by destroying a little bit at a time the faith and trust of one toward the others--a quality or attribute that I deem with much importance in the long run success of a group effort such as ours.

On the whole I do think that the group did work marvelously well together, and cannot think of enough credit to give. I just wish I knew how to enumerate all the positive aspects of this past summer. However, when we open for the day and as we are seeing people we are obligated to give them the tests and physical while they are there. If a person is registered then he is entitled to receive everything. However, I ran into counter beliefs on two occasions. One was at Habersham when John Sperry refused to do blood work on a patient of mine who fortunately was able to return the following day without much difficulty. This incidence may be partly explained by the fact that we were trying to shut down a little early in order to go down to Dr. Burrel's home, and most of us left at that time were under the impression that there was a very definite time element and/or limit to be down there. Consequently, I felt caught between the two situations. Only after arriving at the Burrel's did I find that it would have been possible to reopen the blood lab. The other occasion was at Deer Lodge and Bonnie Maxwell was the one who got all riled up at the thought of more work and opening up again. The people had closed down on their own, without seeing if more people were coming through. Of course, it burned me up to say the least; Jim was his usual great self and did the job for me even though I offered to do it all. I believe that he recognized the premature closing and that I had been doing my part of the project and that I fully expected the others to do theirs without my having to assure myself of it. On the other hand, I recognized the importance of considering their point of view and the need to shuttle the last people out there first. If I am correct we once

again began to send most of the people out there first and avoided the problem for the rest of the week. I am convinced that when my segment of our operation is preparing to shut down, that someone from that section must make a thorough canvass of the premises and make as sure as possible that there is no one remaining who needs the services of that department. For the misunderstanding and anger that occurred this summer, care can avoid all of it, but there is no excuse for what happened. There needs to be give and take on both sides, and I tried to assure the give from the room in which I was working, but there is no excuse that I shall paid heed to if it means shortchanging a patient unless there is substantial grounds, and those that Bonnie gave were not what I considered substantial. In the case of John Sperry, that is a debatable situation.

One small frustration I had was in my efforts to talk with Bill Dow. I never was able from the standpoint of time and circumstance to engage him in a serious conversation. Once there was an occasion on Mount Le Conte, but again something happened which broke the pattern of the conversation. Of course, I am not the only one who desires the attention of Bill, and there is always competition. I suppose that there were many occasions that the potential existed for such a talk, but that there were items that needed to be taken care of prior to a rap session with anyone. There also was the attitude that another chance would come. Perhaps I should have followed the example of others, and when the last patient was done, then time was mine and not the project's. Somehow I cannot accept that totally for there are times that when such as assumption is entirely justified and then there are times that when it is not and times that are debatable. I am confident that by bits and pieces that I shall discover what Bill Dow thinks; I am very curious to know.

I do not wish to make any comment here about the follow-up people for I do not believe that I understand them or their position to do so. I believe what was necessary surfaced at the debriefing session. One point cannot be over-emphasized is that more dialogue between medical students and follow-up people is imperative.

Project

There are many questions to answer about the project, and I am not sure how I feel towards all the various viewpoints and directions since I spent most of the summer trying to find out what the project was all about. I was never aware of the circumstances and the reasons that we went into any community; I can only surmise by what fragments I have heard throughout the summer. In some of the communities there was a health council of sorts and they were told that a mobile health unit was being organized and would they like it to come to its area and conduct a health fair with them. That's my understanding briefly. However, in other areas, Sneedville and Deer Lodge, there does not seem to be a health council existing now and our follow-up people are there working with local people trying to get them interested in wanting one and doing the work that it takes to organize one.

This is a different aspect of our work in which we go into a community and attempt to make it health conscious. In Habersham a few local people are trying to do something because they are concerned and interested in getting others interested, but they are having difficulty in doing just that alone. Mrs. Haskel Ray, in whose home I stayed while in that area, is one of those people, and there is a four room house that needs a lot of work on it that they might be able to get. It really does not have the room that a clinic needs, but it will do for starters. Perhaps if something gets off the ground then others will become interested and better things will come their way. Apathy is their biggest enemy, for there is I am sure other needs that rate a higher priority than health in that area. That last statement is not based upon the number of people seen in Habersham, which was a function of some lack of organization as acknowledged by Veeva Reese, but more upon the numerous talks I had with Mrs. Ray.

I suppose one thing the project was to accomplish was to get individuals to look at the present situation and question it. To look and wonder about the possibilities of change. To try to think originally in new directions from other people as well as on other's ideas to find fault, improvement and approvement. Getting more doctors in many of the areas will not solve the problem, nor could something like that be accomplished in a few short years. I doubt that even men from the areas of Appalachia would want to go back to Clairfield, Habersham, or Briceville to do work there. Not that there is anything wrong in practicing there, but it is one of pure economics. The people are poor and I doubt that any of several communities could support a physician. There would probably be enough business there, but few people could pay beyond a token amount. It is not that I am monetary minded, but it takes money to support a nurse, other staff members, have equipment and an office, and derive an income. I don't see the federal government any time soon paying a doctor to have a practice in one of these areas. My entrance into medicine has not been a blind one. I know that a number of men enter this field for monetary reasons, but my having come from a well-do-do family has enabled me, I think, to be partly independent of that influence. I cannot ignore the influence of the prestige of being a doctor nor the important desire to treat people I have seen many people who were idealistic in college change when they began to earn a living and the dollar took on a whole new meaning. I have wondered at times how I will be influenced by the dollar when it comes time for me to be completely independent and the dollar will for me have a new meaning. I wonder how my idealism will change over the next few years and wonder what monetary demands I will have when $300 per month will be insufficient. Time will tell.

If the government is going to enter the area for delivery of medical care through the Appalachian Regional Commission (ARC), then I see governmental support (financial) for clinics that would be working with a hospital or a consortium of doctors in a particular city. From the standpoint of efficiency the use of personnel and facilities, I would think that it would be best to have a hub of doctors drawing patients from a radium of 50 to 100 miles. The physicians would not have to be in one city, but to maximize the effectiveness it would seem better if they were in a small area rather than widely scattered. Jellico has been the focal point of much discussion this summer and it might prove to be a good model. If the new hospital were open and staffed with doctors, then it would be the hub for areas like Clairfield, White Oak, and Habersham which would have clinics run by paramedical individuals be it a nurse practitioner or whatever. The doctors possibly would go out to the clinics once or twice a week depending upon the number of clinics served and the number of people who normally would come. Method of payment is a big problem, for close to 100% of the people would only pay a little of their bills if any. Therefore, it is going to be necessary to have outside money to support the whole new system. Obviously, the finances will have to come from some level of government. I think that it is outside the scope of this evaluation to discuss all the ramifications and problems of massive governmental support. I do want to say one thing and that is any group of doctors that might be working in a set-up that has been vaguely described ought to be allowed to have private patients if they so wish. Physicians within university medical centers are allowed to have a limited private practice, and perhaps guidelines from that could be used in the rural medical centers. Another alternative would be to have salaried physicians (as public health doctors are) who strictly work out of the hospitals, the clinics, and the rural areas. I know in this way there would be two systems, a private and public one, but with proper connections the two ought to be able to work in harmony. What I do know will not work is a totally socialized system as in England.

In a broader scope there could be an expansion of this wheel and spoke theory with cities like Jellico and/or Lake City becoming a spoke for a larger medical center such as Vanderbilt or UT Hospital in Knoxville. Prior to this summer and from discussion held at Georgetown, I have had dreams of Chattanooga becoming an organized center for the area surrounding it. One additional problem to making it a large center is that Vanderbilt and Emory are not too far away; both are within three hours driving time.

The creation of change as old as medical practice is a massive undertaking and I do not think that the project bit off more than it could chew. The physical being of the project--the health fair--is of a very limited life and use. I can see it only as being the seed for the local poor people (and I suppose that it does not have to be limited just to poor people) to demand services and/or a system

that does not exist or something. The health of a community and the type of medical care it receives is a community affair; it is not something that should be pushed upon the people. During the orientation at a meeting at Meharry in which the Point Byou program was discussed, there it was found that health was not a major community priority, but was about fourth or fifth on a list of major concerns. We talked to many people throughout the summer for whom health is a major concern, and I sometimes wonder how representative it is of all the people who would be affected by any program instituted. The people who might be affected are not only those in the immediate area whom we can see readily, but also those back up in the hollows, who really in all liklihood are not totally aware of the new development. Of course, for many in this category, there are those of us who would probably discredit their opinions and assume a superior position and plan for them ourselves. All too frequently that is the case in other matters aside frm medicine, and the poor and ignorant are not allowed to express their own ideas, even though it will be in a way crude to those of more sophistication. I am sure our student leaders are at least minimally listening to the loaal people if not more so and conducting dialogue with them. How much of this is going on I really cannot say, but from what I have heard it seems possible to get a community interested and have them form a health council to conduct business and plan for their community and supporting the whole set-up of a clinic. In this way it is community sponsored and directed--it is theirs rather than set up by an outside office of bureaucracy. Finances or the local effort are not known by me at all.

After several days away from the typewriter and hoping that the vacation would allow new ideas to come into view, but that has not been the case. Even after the debriefing sessions I have nothing really to say having made replies to what was said rather than making statements. Besides I believe the ideas of what I said that had any substance was noted by Ann Baile. (At least that is my assumption as to what she was writing during the meeting)

The only idea that I have is to have a nutritionist or an aide connected with the clinics to aide and assist the rural people to have better diets on what they eat that will not be so unsatisfactory for them. Perhaps they could help stem the tide of fat women that we saw all over the place. I think that everyone is aware of the deeded improvement in most of the people's diet.

I hope that not all of what I have said has sounded like criticism, but I am banking on that each of us knows generally well all that was right and successful this summer. I am aiming my remarks not to be mean or give the impression that everything was wrong or nothing was right, but in hopes to give ideas that lead to improvement. I know from the debriefing session that next summer is bound

to be very different from this one all the way from the way the health fairs are conducted to the set up and equipment used. Once again I enjoyed working with everyone and really hope that our influence keeps going and the project. If everything works out, I hope that I can be a part of next summer's project for either part or all of it.

First of all, I want to warn the reader that I am a poor writer and am unable to express myself well. Most of my experience this summer could not be put into words by a true literary artist.

The equipment of the mobile unit was generally quite adequate. Improvements could be made only in small details, such as gowns, sheets, examining room partitions, and instruments for examiners.

The main problem of the entire mobile unit operation from which almost all our problems resulted was the fact that we were overworked. Because we did not want to turn anyone away we attempted to see more people than was possible. Therefore, we remained tired, had no time to ourselves and when the workday ended did not have energy to get to know the local folks as much as I would have liked to. The efficiency of the mobile unit was great after the initial "shakedown". However, a lag appeared after much pressure from the leaders to work harder during that time. As it was, the seventh and eighth weeks, we no longer hesitated to make patients wait while we took a short break. Overall, the efficiency was great with problems due only to the tiredness of the workers.

There was definitely tension among groups, especially among those on the unit. Medical students and nurses became angry because one person was not doing as much work as the next. We were all so interdependent that if one examiner slowed down or quit for awhile, more patients were left for the others to see. Other tensions occurred between mobile unit people because some would not exchange jobs. Naturally some jobs were more enjoyable than others and some enjoyable for a limited time period. More personnel, especially medical students and doctors to examine patients would remedy the overworked situation and relieve most tensions. More doctors to supervise would give the students more confidence, speed up the bottleneck caused when the examiner must wait his turn for the supervising doctor to look at his patient.

The satellite health fairs at Kentucky Hill and Elk Valley were very good. With more work on the community organization by the parent Health Fair's follow-up people, enabled by having one or two more there, the small fair would be more effective. In the satellite fair in Elk Valley, in which I worked, we saw a large number of people who needed medical care. Satellite one-day fairs would enable us to reach people unable or unwilling to leave their "holler" or community to go to the Health Fair in the neighboring "city", to which they are hostile. Those people secluded in the hollers are usually the ones who need medical care most and who may have never seen a doctor.

As a non-medical person, I do not feel that I can judge the quality of medical care given. I do feel that it meets up with that given by a

rural general practioner who, because of his patient load and/or attitudes, is unable to give each patient much time and attention. Being better able to spend more time with each patient to give a complete physical exam we served the psychological needs of the patient. A doctor with the patient clientele of a rural doctor does not have time to listen to all of each patient's problems. Further conversation with the patient often provides clues to a medical problem which was not ascertained by brief examination and questioning alone. An attitude of acceptance of the patient by the doctor can be as much a treatment as a drug for "nerves".

Changes could be made in our operation to improve the medical care given. Two more doctors on the staff, one for women and one for men, as Dr. Moss was in pediatrics, would improve the work of the students by having a doctor whom they know well ready for consultation at all times. These doctors would be aided by visiting doctors, such as those who visited this summer for a few days or a week at a time. The visiting doctors were not enough because, for example, sometimes there were three pediatricians and no one with recent gynecology practice. Including parent's names on children's records and phone numbers when available would increase the efficiency of follow-up by making children's homes easier to find. Having local people with follow-up people during home visits would decrease the amount of time spent looking for homes. Publicizing that parents bring their immunization records, if available, to the fair would make the immunizations station more efficient. With the records, the nurse would not have to spend time questioning to determine what shots patient's have had and when. And information determined by such questioning is not always reliable. Thus, the immunization of the area would be more effective. More cooperation from the local Public Health Departments in loaning their records would provide many of the needed immunization records.

The impressions of the project made on dignitaries who visited are important. Our work depends on them. It is important that they get a realistic picture both of our work and, especially, the people of the communities. That picture is hard to obtain in one day. A visitor needs explanation from a staff member as well as first hand experience working in the fair or talking with local folks. With the heavy patient load, I, and others, felt hostile toward visitors because the time spent by the medical student showing him around took the student away from his work. That meant that others had to see his patients. Next summer a nonmedical person should have the responsibility of showing visitors around. This person could keep informed of the broader aspects of the project, such as new clinics formed by Health Fair-initiated local

Health Councils.

The education of Mobile Unit Staff members would be much more complete if time were spent doing follow-up work. During the week I spent making home visits and calling on local doctors I learned much more about the community. Only by visiting a number of homes did I realize the poor economic conditions in which many live. In these conditions lie their basic problems. Visiting one man to discuss his diabetes we found that his daughter had impetigo and his wife had an ulcer. Neither had gone to the Health Fair and both needed medical care. Rotating staff from mobile units to follow up would 1) enable medical people to follow-up their own patients and 2) provide them with a change so that the fun of medicine would not become "work". Following their own patients will give better patient care and more medical education to the student who sees what treatment the specialist gives. I recommend a rotation where a student spends two or three weeks with the mobile unit and then goes to one of the communities to work on follow-up. With more medical personnel, major follow-up could be finished sooner. The last Health Fair should be at the beginning of August so that enough people will be available for follow-up work. This year, because we understood our work to end around August many of us had already made other plans when we learned how much work was yet to be done.

The project has taught us much. Nurse practitioners and other paramedical personnel can and should be utilized to relieve the medical care problem. A team of doctor, nurses and others can effectively care for a far larger number of people than doctors alone. General practitioners are inadequate because they must refer patients to a specialist in many cases. Why can't a nurse practitioner do the same, fully realizing her limitations, so that the extensive training of an M. D. is not underused on common easily diagnosed and treated cases. The four year college R. N. is trained beyond what she is allowed to do as a nurse.

The training of medical students is too much limited to science. A doctor's treatment includes understanding a patient's economic and mental status. In order to get doctor's to work in rural and ghetto areas, their training should include experience in community medicine. Without exposure to <u>all</u> aspects of our society one cannot attempt to evaluate and solve the societies medical problems.

Contact medical problems showed other problems. The root of all problems in the Appalachian area is the lack of jobs and work. Young people leave. Old people remain without money and live poorly and in poor health. We can help them some by "curing" their diseases, but good health requires prevention of disease - clean water systems, warm clothing,

nourishing food, and health education, all of which require money. The Student Health Coalition is trying to create local awareness of health and be a catalyst for local initiative. However, without local money, groups must seek funds outside the community. If jobs provided people with money for health care clinics could be financed by the clients. The lack of jobs also creates mental health problems. With nothing to do many men lie idle and drink to relieve the minds of their miserable economic position.

Having no jobs, many families must rely on welfare. The present structure of the welfare system gives a man more money than he would get on many jobs. The welfare system would be restructured to include incentives. Wouldn't you not work if you knew you would receive more money not working than working.

As in national issues progress is slow due to local politics. Families with power, in money or land, hinder projects which will benefit the community. For example, in Clairfield, the office where records of Marie Cirello's work were was burned by someone who objected to something she was doing.

Although I have deeply criticized the project, it is very worthwhile. Not only have several clinics been started in areas we visited, but plans for other projects are being made. Similar education of participating students could never occur in a classroom. We learned about a way of life entirely different from our own.

Sarah Graf

Let me preface this evaluation, for anyone who is interested, by saying that this summer was probably the most rewarding and educational experience of my life. You can read books until you are blind, but until you are actually a part of a way of life you cannot really understand or appreciate it. And even then, seven weeks was too short - but the project still lives on ....

My criticisms of the project during and at the immediate end of the summer were fairly numerous and intensely felt, but with the passage of time they have faded into the background and my positive feelings have taken their place. This is probably as it should be, but I will try and put down on paper how I was thinking and feeling at the end of August, because positive criticism is the root of change.

My greatest concern is the quality of the care that was given. There is no doubt that no one can complain about the quantity of work consumed - but it did reach a danger point. A human being can only do so much even when he cares a great deal about his work. I feel that next summer we should concentrate on delivery of more thorough health care. This could be accomplished by either increasing the staff and have shifts or by cutting down on the number of people we can see. I can remember, late one day, having to stick a small child twice to draw blood. If it had been that morning, I know I could have done it on the first try.

I think the quality of our health care would have increased had our preparation for the summer been more thorough. I feel that the nurses should be better trained in the anatomy and physiology and pathophysiology of the child and that the adult physicals should be performed only by third and fourth year medical students. Classes concerning the Appalacian region itself and the agencies available in the area should definitely be organized. And perhaps the law students could begin their work a little early by teaching the medical staff a little about Medicare, Medicaid and other relevant topics.

I think that lay people could be employed much more efficiently. They could draw all the blood, run the blood tests, and then do all the EKG's, X-rays, etc. as they did this summer. This would allow the medical people time to concentrate on physicals.

Follow-up is a great concern of mine especially since I spent four weeks doing it this summer. I think it is necessary to have a medical person in the group that stays behind to do the follow up. All follow up people should be well educated as to the facilities available to them - perhaps a special course for them. If possible, it might be a good idea

to have a law student in the group. This is the most important part of the project, I think, and a lot of thought should be given to this area before next summer.

I liked the living arrangements and I think everyone on the project should have to spend a few weeks at least living with a family. Not only is it fun, but it is educational and some people will never know how much they missed by passing up this opportunity.

I am very happy that I chose to join the project last summer and I hope very much that I can be a part of it next summer.

Betsy Weil
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The nurses acted in many capacities this summer. Some were located in communities doing home visiting, teaching and working in various clinics. Most of the nurses, however, worked on the mobile unit doing primary screening of both adults and children.

Looking back in retrospect, I feel I have some valid criticisms and helpful suggestions of the summer's work.

The nurses working on the physical exams mainly emphasized pediatrics with one other nurse working in the adult area. I feel the nurses lacked knowledge and experience of pathology to determine the real significance of their findings. They also may have missed subtle clues to pathology due to their lack of experience. I also feel the nurses along with the medical students began to function mechanically, almost like technicians. They looked at bodies and lost sight of other factors of the individual, i. e. emotional, cultural, family relationships etc. The emphasis was placed on the physical findings and very little of these other aspects. There were many reasons for this to happen, 1. the number of people screened per day were for too many to do anything else except a mechanical physical, 2. students were overtired from long hours, 3. not enough time available to spend with each individual. I feel these are the areas of the past summer that must be looked into and improved for the next summer.

However, I feel there were so many positive aspects to the summer's experience that they far outnumber these other factors. I feel the nurses learned a tremendous amount about the normal child - physical as well as growth and development. Again time was a limiting factor and hindered their learning experience. The nurses, however, became very keen observers, being able to detect the abnormal from the normal. They were able to pick up many significant findings. Examples include strabismus, pneumonia, otitis media, visual disturbances, hearing loss, tonsillitis (culture throats and determine causation factor), T. B. (thru T. B. skin test), Chronic lung disease, heart defects, sciolosis, various gaits with unknown etiology, inguinal hernias, urinary tract infections, impetigo, mental retardation. These are just a few of the findings that come to mind immediately. The nurses were not able to diagnose but picked up significant findings for the doctor to make the diagnosis and initiate the appropriate treatment or follow up. I feel the nurses did an outstanding job. Many of these findings might have gone undetected if the students had not attempted this project.

This summer also introduced the nurses to the problems that exist in rural communities. It has made many of the nurses including myself aware

of the dire need of the expanded role of the nurse in the community. I feel a nurse will need to become an initiator of health care delivery. She must improve and expand her skills to meet the needs of the people. She must be aware not only of the health problems in the community but the many other factors influencing and shaping the lives of the individuals, social, economic, political, etc. The nurses from this summer, now want to begin to take on new responsibilities as a nurse. Of course, this means new concepts in nursing and changes in traditional roles, but I feel this has become imperative to help begin to solve the health crisis existing now.

Recommendations:

1. The nurse or medical student should do the entire family as a unit instead of one medical person doing one physical and another person examining another member. The medical student and nurse might combine their efforts and together look at the family. They would then have a broader understanding of the individual besides his medical problems. If indicated, the medical student and nurse might work out a home visit to the family for additional information, teaching and care. This would present a more comprehensive health plan and would help eliminate the impersonal atmosphere of the past summer.

2. The orientation program must be expanded if the nurses are going to function in this capacity again. More training in history taking and experience in screening are imperative. Further recommendations on this have been written by all the nurses from the summer.

Personal Evaluation
M. H. Anderson
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Let me begin by saying that I didn't know what I would feel about this summer experience, but I did know how I would feel. The experience was rich, to say the least, and this I knew would be so. But this critique is both laudatory and somewhat harsh because if many aspects of our operation are unchanged next summer I could only be more critical, and no more pleased with our efforts. To say we must change is self-evident -- how we change is part of the purpose of this work.

Many remarks should be directed to the operation of the mobile units themselves. It was obvious early that the only feature of the TVA equipment that was essential for our health screening was the x-ray machine. All other work could be and was performed outside the walls of the mobile units (e. g. Elk Valley and Kentucky Hill satellite clinics). One essential feature of the TVA units that may go unappreciated is the tremendous demands of materials made and answered by the TVA men throughout the summer. Jim Pulliam and Larry Napier worked as many, if not more hours than most of us, but it is doubtful their efforts went unnoticed or unappreciated.

One gripe that might be aired is that regarding the supervision of the medical students and nurses in their execution of the physical examination, especially the examination of adults. When possible, it would seem to be better medicine to have at least third year students doing adult examinations, since the novice medical student or nursing student can not only miss subtleties but can develop bad habits, resulting in sloppy medicine. Realizing fully well that our demands for upperclass medical students were not met, we might suggest a realignment of our goals toward more screening of children and less of the chronically ill adults. One suggestion that never really bloomed regards the possibility of prescreening the adults before a physical exam in order to determine if there is untreated pathology present. This might alleviate our patient load of healthy adults, and enable us to screen more children. Is a medical student fresh from neuroanatomy and a crash physical diagnosis course equipped to do adequate physical exams on sick adults? Sometimes yes, sometimes no, to my way of thinking. Closer medical supervision, by physicians, is best for rooting out more pathology. Differentiation of disease processes, if there is abnormality present, requires more than most fledgling medical students can supply.

There were, at times, tensions that arose either intrinsically or extrinsically between the different groups working with the mobile units. Most of the time, these tensions were personality or method

clashes, and in my opinion, inevitable. Such clashes probably helped us find out where and with (or without) whom we worked best. Much of the tension seems to have evolved from overwork early in the summer, and we later wisely chose to limit our time while improving our efficiency. It would seem that in the future, the people planning the health fair in a particular community might consider that long hours do not necessarily make a better health fair. In some communities our schedule for work was easy to abide with; elsewhere, hours were less gratifying. The marginal returns of remaining open some extra hours should be borne in mind when we consider that we are not interested in quantity care, but rather, quality care. Perhaps Saturday should not be thought of as a day to catch stragglers but more to add flexibility to our schedule, should we anticipate the need for additional hours. Those working in packing and unpacking the mobile units appreciate a job done with ease on Saturday morning and not hurriedly on Saturday afternoon where the group would try to enlarge upon the brevity of a day long weekend by hastily stuffing everything of value into some spot on the mobile vans.

Mentioned before, but worthy of some embellishment, are the satellite health fairs. The health screening at those fairs was, as was intended, comparable in most aspects to the core unit screening process. Lacking, of course, were the x-ray machines that could provide us with immediate films, but the film results were made available to us. For small communities these health fairs serve the same purpose as the large one; they have the same shortcomings, but their virtue lies in the fact that health screening, of any kind, would remain undone were it not for some sort of health fair setup.

As a novice to both medicine and health fairs, my work was in general quite interesting and rewarding. There are better teaching experiences one can have, especially those with erudite supervision as in a medical school, but insofar as field work is beneficial to the student, health fairs do instruct in a way peculiar to health fairs. Certainly health fairs are geared for screening and not instruction, and this fact should be remembered is assessing just what we hope to accomplish in a summer or two. When we ask what kind of service the people did obtain, we cannot think solely in economic terms; surely the tests were free, but are these people seeing a chemistry major or an almost physician? Most, I'm certain, thought they had seen the latter, at least. And then again, the screening we provide would not be done were it not for us, but can we do better than personnel trained two weeks for adult screening? When we find something, can we be consistent in reporting it? These people

need doctors, and if they are not available, the best medical student will have to assume their position. As it stands, we probably did the best we could with what students we could recruit, but we should perhaps remember that there may be some efficacy in prescreening adults for complete physicals. It might work.

As an aside, but important to the mobile unit people, are the accommodations we received. It should be, and was, a personal preference with the men as to whether they moved into local houses for the duration of the week. Mobile vans often housed the men, but perhaps the women deserve a choice also. Living with families was often quite an enjoyable experience, discerned from afar by me, but the weeks were not always rosy, as could have been predicted. Generally, the reception by local people into their homes was gracious, and most hosts and visitors reciprocated with tales and thoughts, which is only as it should be. Best of all, most of us made some good friends.

There were definite differences among the eight communities in which we held health fairs. To my way of thinking, Briceville was perhaps the most gratifying, Clairfield perhaps the least. We know Briceville had been working diligently through their health council and Byrd Duncan, to make our stay there comfortable and worthwhile. Not all communities had the organization that Briceville did in preparation for a health fair, nor did they have the facilities or attitudes toward health fairs. We really needed all that space in Briceville to keep the crowded feeling subdued. Towns like Clairfield, though they held a successful fair, seemed a bit more aloof from what possible health problems might exist there. The petty squabbles that were festering there and our alignment with nepotism as practiced in Claiborne County may only have dulled the senses of a people that needed a health fair in the worst way. Certainly our friendship with the Teagues is necessary and was not unstrained, and it is not the fault of the people who invited us that Clairfield came across as it did. Their facilities were not adequate, and the Teagues may have appeared to some to want the health fair more than the people who really brought it. Everywhere the gratitude of the people towards our coming was quite obvious. The challenge of holding a successful health fair is perhaps greater in a community such as Clairfield, where the people's fighting amongst themselves only detracts from their attentions to their health problems. The challenge as far as medicine is concerned is the same; we cannot deliver adequate care throughout the year, nor can we avoid sloppy medicine if our methods remain unchanged.

I have already suggested some alterations that might be made in the delivery of the physical exam (i. e. prescreening and screening adults

by upperclass students). Just a larger operation next summer, with our radical changes, will not be sufficient, and will only demonstrate that we cannot learn from our mistakes. As regards the physical exam findings and followup we should be more consistent in our approach to the same illness as a group. For example, once we find emphysema in chronic smokers, do we stop at sending them to a physician? What will the local doctor do for the patient? Will this treatment be adequate? The history forms, condensed as they were, were probably not used to their best advantage. Significant complaints may have been overlooked by some from ignorance or others by carelessness. We might consider that since we cannot deal with all the illness in the mountains, why make it look like we can. We are not honest about our limitations concerning how many people we can care for adequately. Followup work will go into the fall -- there we need more workers.

Something might be said concerning the dignitaries ushered about our operations. Realizing that our politicking brought results in money and materials, and that Vanderbilt is interested in her field workers, will all the politics and solicitation of smiles be necessary next summer? Personally, I was not bothered by the dignitaries because my job was identical with or without their presence.

Our summer of health fairs only makes it obvious how much health profession personnel, especially doctors are needed in the mountains. And there should be incentives for working there, like government subsidies for facilities and the hiring of paramedical people where needed. Itinerant nurses such as Sister Martha are rare, and certainly much needed. The people need to be educated in matters of health. But certainly the problems of Applachia extend beyond health deficiencies. Until some of the economic and educational poverty is overcome, such problems will persist. I ask myself why should I be doing the worrying for these people regarding their health when in my opinion their health problems are as much a part of a fatalistic approach to life as they are due to a deficient health care delivery system. Will just education make the people more mindful of their health care, or will the people expect modern medicine to repair or replace what they have neglected.

Not wanting to sound too socialistic at present, I believe it is the government's responsibility to care for its own, from cradle to grave. A large order, no doubt, but one that is becoming more necessary as we uncover our health care problems. Medical care should not go just to those who can pay for it, but to those in need of it. Good health should not be beyond the reach of any individual. And then we worry about the

autonomy of the physician when the government steps more into health care. Medical education would need some revamping, away from development of specializations and toward family practitioners in the rural areas. Whether this alteration of direction and self-regulation is possible is an equivocal argument, and it remains difficult to find doctors and adequate health care in Appalacia.

In a word, my own experience was invaluable. The merits, and at the same time, the limitations of such health care programs such as health fairs, should be widely disseminated to all conscientious people in health professions. Maybe if we can't help the people here, we can teach them to begin to help themselves find the answers to a stagnant health care delivery system.

Personal Evaluation

April Taninecz and Darrell Paster

Job: Follow-Up

Location: Hancock County (Sneedville)

In trying to discuss "the community" we dealt with, a major problem effecting health care in the county immediately becomes evident. Hancock County consists of several communities which lie outside of the town of Sneedville. Government and Foundation funds going into the county go through Sneedville, the county seat, and most remain in Sneedville. Instead of actually developing any of the communities outside of Sneedville, the funds stay in Sneedville. The town acts as a first aid station for those who can afford transportation to the town, and can finance most of the aid themselves. This situation applies on other levels than health care.

Recommendations

1. Concerning Community Center Planned for Sneedville

The problem mentioned earlier about money and programs remaining in Sneedville is exemplified in the proposed community center is probably not without reason; however, this aid will not further develop Hancock County. Aid will be a one-shot deal contributing to a better community center for those who can manage to get there. The administration of the community center will be by the bureaucracy in Sneedville and not by those it is supposed to serve. (Again preventing development of initiative of the people). The planned health facilities in the community center will be located in the same geographic area as the health department, and will be aimed at the same people. It would be more effective if the funds were used to develop a health council outside of Sneedville in one of the outlying communities. This would be more rational in two respects: 1) The actual health needs in the outlying communitis are greater, 2) the communities would be more likely to provide their own leadership and administration - and thus would be developing their communities.

2. Future Health Fairs

Health fairs in Hancock County should be held in outlying communities and not in Sneedville. The fairs

could be held in areas north of a line running from Kyles Ford above Sneedville up into southern Virginia. The purpose of the fairs can go beyond merely broadening health consciousness - although this is a necessary first step. They can help develop health conscious groups into ongoing health councils.

3. Dental Care

Statistics from 1970 summer health fair concerning caries in Hancock County should be given to Dr. Huffman, Greenville, Tennessee, Public Health Administrator. Dr. Huffman is working with the OEO in trying to secure a dental mobile clinic with a salaried dentist to travel throughout this (and maybe other nearby) counties. This is merely in the planning stages, yet our statistics might further the stage of planning.

4. Special Education

The county needs at least one special education teacher. The rumor has it that the county does not have a special education teacher because they would have to hire someone from outside the county. We do not know if this is a valid observation or not. The principal of the elementary school in Sneedville, Dwight Snodgrass, seems eager to get such a teacher. (His teachers do not want to have to deal with children needing special education anyway)

5. Future Health Care Planning

Obviously the county needs more local medical (nurses) personnel serving on a salaried basis. The optimum would be to get a mobile health unit to travel throughout the county. An alternative would be to have small local clinics in outlying areas. (Example: the Alanthus Hill Health Council has talked of using the old negro school, now closed, as a clinic). The Health Councils can develop health care facilities through grants in the form of a mobile unit or a clinic. At the same time the group's activities can be integrated with economic cooperative efforts on the part of the group. This is to be understood as part of a general broadening of the aims of the health council. Health care itself must be defined to include more than medical care. The health of the people in a community and thus the community itself is dependent upon the economy of

the community. Jobs, water supply, food (food stamps) etc. are as much a part of health as medical care. In other words, the health council will broaden its definition of health care as it grows in strength.

Supporting Data

The area where the present health council is located is on Four Mile Creek in Alanthus Hill--one of the outlying communities with special goegraphic problems--especially in winter when access to the Public Health Department in Sneedville is virtually impossible much of the time.

The leadership in Sneedville can be understood by remembering that Sneedville is the county seat and the largest town (700 pop. in a county of 7000 people). The bureaucracy includes a Welfare Department upon which a great proportion of the county's population is dependent. The OEO has an organization of "local people" to coordinate OEO activities in the county. This organization, the C.P.C. (Citizen's Participation Committee) includes many of the "powerful" people. Because of the makeup of the group, despite sometimes sincere (paternal) attempts, it is an ineffective group. The C.P.C. includes the County Judge, local wealthy people (income $3000 and up), the only doctor in the county. (The doctor's power is seen by his wealth, he is chairman of the School Board and in effect "owns" the only hospital in the county). The beauracracy also includes the county road commissioner, county agent, etc.

Poor people throughout Hancock County have organized in the past in resistance to the power structure. This has been done with the help of VISTA volunteers and has usually been unsuccessful (The lack of success measured on two levels: 1) lack of concrete or many quantitative changes in status quo, 2) spirit of people are wary of organizing because of past experiences.)

No health group existed when we entered Hancock County. The health council grew out of a C.P.C. Health Fair Committee. It included C.P.C. members and was open to anyone in the county. It turned out that only two members of the C.P.C. actually remained active in the health council. The two members are representatives of target areas in the county. (Target areas roughly correspond to the outlying communities mentioned above)

The health council did not seem to have opposition, although it is becoming apparent that some people are afraid to participate because they think the council is associated with VISTA. (This

would prevent them from participating for fear that the Welfare Department would cut off their checks--as it has threatened in the past with welfare rights organizations)

The people in Sneedville know this health fair (as the fairs in the past two years) were "sponsored" by the C.P.C. (and thus the O.E.O.) The people throughout the county could not perceive much difference this year. The "health consciousness" throughout most of the county is on an individual level--which may seem hard to accept, but is a good first step. A small amount of people--those interested in the health council (in Alanthus Hill) have become conscious of their own potential. They see their role as actual providers of limited health facilities (taking blood pressures, checking urine for sugar, checking eyes and ears). In this way they hope to gain strength, respect and self-confidence. The main thing missing and needed to develop any people's organization is self-confidence. The initiative of the health council in providing limited health services is a good way to build up such self-confidence.

The health council overcomes the main stumbling block at its first meeting--it elected a chairman (Carl McMurry) who is an excellent leader. The group would not have developed without the excuse of having to put on the health fair.

The group still has several problems to deal with. Some of these are:

1. Fear - Some people do not want to participate because the health council might be associated with other VISTA type poor people's groups (welfare threats)

2. Priority - People are busy farming, cutting tobacco, etc. and some are apathetic about the health council (whether it be because of past experiences with groups or a real lack of interest).

3. Transportation

4. Medical facilities

5. Securing more local medical personnel

6. Small area base - Alanthus Hill. Expansion to a larger area still needed.

Present Medical Facilities

1. Sneedville Hospital - private, one doctor, 17 bed, now

being expanded to hold 35 beds.

People with insurance or Medicare, Medicaid are admitted. (Poor people who qualify for aid are, therefore, sometimes in the hospital. In fact, Medicaid patients sometimes stay in the hospital, when its doubtful if hospital care is necessary, until their Medicare runs out)

2. Health Department - Includes following services:

a) Home-visiting by public health nurse - extent of home visiting depends on nurse. The year replacement nurse does a lot of home visiting. The regular public health nurse thinks people should have enough initiative to come to the Health Department if they want help.

b) Clinics

(1) Weekly Clinic - open to anyone for shots, skin tests, etc.

(2) Family Planning Clinic - held once a month, Dr. Huffman (public health doctor from Greenville) comes to Sneedville to give PAP smears. Therefore, Dr. Huffman is in Hancock County approximately 3 hours per month. (The doctor in the hospital does not give PAPS or insert coils for birth control)

(3) X-Ray Clinic

T.B. x-ray van from East Tennessee Chest Disease Hospital gives x-rays every two weeks to check up on known, inactive TB cases, and to check those with positive skin tests.

Personal Evaluation

Ann Baile

Job: Nurse
Location: Smithville - 3 weeks
White Oak - 7 weeks

I only worked on the Mobile Unit the first two weeks and felt we were inadequately supervised and inefficient those two weeks. I am sure this changed as the summer progressed. I did hear from one local health department nurse that she felt we did not let local health departments know what equipment we needed enough in advance for them to order it.

I felt that there were people doing examinations who were not competent medically (as reflected in their work-ups). Perhaps better supervision and each examiner doing his own follow-up would help the quality of care given. I found the work on the unit interesting, except when we were terribly rushed or when I had to do the same job more than two days (other people seemed to enjoy having the same job). I do not feel the people at the Health Fairs got the kind of service we had hoped to provide - most had to wait more than 2 hours, were herded from one station to the next, had limited personal contact with our personnel, and little or no immediate follow-up.

Satellite fairs were valuable this summer in seeing people who could not travel to the main unit. However, in planning these for next summer more attention should be paid to insuring both community participation and adequate follow-up. If we could not have the personnel and time to guarantee the above, I think a "one-shot" satellite fair would be worthless in the long run.

The greatest value I received from the summer was the opportunity to live with a family. There is really no other way to understand the community and I think those of us living in communities felt the mobile unit people only got a very superficial idea of our area when they did not live in homes. Perhaps if more time was left free for people to spend with families, if weekends were free, the mobile unit people would be more willing to have this experience. I think it should be a stated expectation of any future project.

I felt the best communities to work in were those that really needed our service - e.g. working in Murfreesboro was a pleasure, working in Smithville was not. Gratitude of the peoole helped too.

Changes in Basic Structure - Set times unit to be open, stay longer in each community, have mobile unit people do follow-up and vice versa, try to encourage flexibility among mobile unit personnel (by rotating jobs, getting off the unit to help with community work).

What impressed me about the people I encountered - Everything! Their patience, their trust in us, their willingness to help and be helped, their independence in spite of frequently extreme poverty.

Kathleen and Charles are more qualified to speak on the questions about the White Oak community group than I am. I came during the week of the Health Fair, and was received very warmly - my being a nurse may have had something to do with this. The Health Council was evidently considerably strengthened by the success of the fair - most of my dealings with this group concerned follow-up from the Health Fair. They were generally receptive to our suggestions - the only specific problem I encountered directly was providing transportation for people to get to distant hospitals. However, we talked this over at a meeting of the council, and generally worked things out - having a local medical secretary to work through was a big help.

Medical Services in Campbell County - I am not sure exactly what is meant here. Generally, I found that people listed private physicians (either in LaFollette or Jellico), but did not regularly see them. Many people went to the Clairfield Clinic and knew of Sister Martha. The Public Health Department did not appear to actively follow families other than active TB cases or Crippled Children's Service cases. However, they were very willing to follow the cases we referred to them (there were many suspected cases of diabetes that I would like to have seen referred, but we were not able to do a strict enough follow-up). The only specialist was an internist in LaFollette, and he saw cases only on referral. The Catholic Sisters did most of the home visiting observed - they were outside any organized medical group (i.e. PHD), and functioned pretty independently. Other than Sister Martha, however, their group was not well known in White Oak.

For immediate medical care, most people went to the clinic, or, more frequently, to Dr. Prater's Hospital in Jellico. There is evidently some sort of ambulance service, but I do not think it is extensively used.

Deficiencies of Medical Care - Mainly lack of medical personnel and any health facility in the immediate area. Also the

chronic problem of payment for medicines and hospitalization. The physicians in the area were not always the most competent, and were fairly rigid in their approaches to problems.

Concept for Developing Health Care in our Area - The concept of outlying screening clinics in the Model Valley with a referral hospital in Jellico appears to be workable, and has already been extensively discussed. Actually, using Knoxville resources for referral purposes would also be feasible, if the red tape could be waded through. It seems to me that permanent clinics with full-time personnel in the main rural centers are a necessity (Clairfield, White Oak, Morley or Habersham) - also, this increased number of medical personnel would allow more outreach (home visiting). Provisions for transportation should be formalized, with a definite person hired to insure this service. It seems to me that getting a coherent system started would require more money than could be raised locally - the outside RMP funds administered locally seemed to work well. White Oak is, of course, in good shape as far as the clinic goes. Local participation appeared to be most effective in providing for transportation, volunteers, and paid personnel. The crucial factor is to make the local group feel this is their clinic. I am not sure whether involving them in every phase of planning and construction of facilities is necessary but it may be.

According to the Welfare Department, 43% of Campbell County qualifies for public assistance. I found them cooperative but beauracratic as hell. We could have made more demands more effectively with more time and personnel.

I did not find any reservations among the local people about participating in public assistance - most people felt they deserved it, for various interesting reasons.

I wondered a lot whether ushering "dignitaries" was not just a big waste of time - sometimes it did waste our time.

Have we proven anything? The fact that we completed the summer proves that student initiated and directed projects can work. I do not think we proved anything medically, because we did not give quality medical care. I feel like we maintained good relationships with the people of our community, and hopefully that will broaden their willingness to work together, and with other outside groups.

Questions posed

What is the best way to sensitize the medical profession to the needs of a rural indigent population?

What is the best way to deliver quality health care in an isolated poverty area?

It may well be that periodic multiphasic screenings would be the most feasible answer to the latter question if adequate follow-up was provided for - I really don't know.

We should thoroughly analyze the data before releasing it to other groups. Main groups to present data to - state and county public health departments, dental associations, foundations who supported us, Vanderbilt University Medical and Nursing Schools. I don't see why we could not release data and report to any legitimately interested group.

Function of Initial Groups

On Mobile Unit, medical and nursing students performed almost the same functions. Accountant and secretarial workers seemed to be "para-medical" personnel, drawing blood, doing EKG, BP, etc.

Law students - good question! Seems they worked on individual cases, talked with many officials in various power structures, "investigated" local resources, supposedly assisted in follow-up (esp. Jane and Rob L.)

Follow-Up - organized community group (quite a job!), worked with them to set up fair, did medical follow-up (the follow-up nurses made major suggestions here, and saw people who needed to see a medical person), investigated local community problems and resources.

I think we just need additional numbers; not necessarily different kinds of workers. Perhaps law students willing to go beyond the "letter of the law." I would recommend three people in each area for follow-up, one of them with some medical background. Also, encourage flexibility of outlook among medical people.

Orientation

Next summer it would be valuable to include an afternoon discussion of what public health programs exist throughout the state and who they provide for. Also, some special programs such as Vocational Rehabilitation, Sight Conservation, Welfare.

Personal Evaluation

Muffy Ecker

Job: Follow-up
Location: Smithville, etc.
Duration of work: 3 months

Mobile Unit

Once the unit worked out its difficulties in technical operations and explored its possibilities, it seemed to run OK, as far as I can tell. Those first two weeks were particular hell, however, not only on the workers in the unit who had to work too long to accomplish too little, but the follow-up workers in Murfreesboro-Smithville were plagued for the rest of the summer with incomplete or over-sensitive diagnoses, poorly written histories, and many problems in relocating people who had given incomplete mailing addresses. About 75-85 letters were returned to us, many of which went to families of large numbers, so that a significant percentage of the people we saw there did not hear from us again. I would recommend that if a similar routine is adopted for next year, the unit begin in a community which has sponsored us before, so that problems with community help and understanding as well as just plain physical logistics are not such overriding difficulties that they prevent both efficiency and enjoyment.

Tensions between mobile unit people and follow-up workers were not yet evident those first two weeks, as far as I could tell. But this was due in part to the fact that the follow-up workers were not familiar enough with their communities to have developed a sense of identity and, therefore, protectiveness about them. It was almost a mechanical procedure in Smithville and Murfreesboro, during Fair weeks as well as during follow-up. As far as I am concerned, those first two weeks' most positive advantage came with the fact that the most was learned in a community where relatively speaking the least harm was done by our mistakes since medical care delivery is by no means a major problem in either of those communities. A lot more could have been accomplished by the presence of the Fair if the community workers had been there a month earlier than they were.

The unit people stayed at the schools at night, a potentially if not really bad situation with boys and girls sleeping together unchaperoned in a community's school house. They most definitely should at least have been offered places in local homes, for appearance sake as well as for public relations. Even if only

5 or 6 hours of rack time are spent in a family's home, the symbolic significance of this sharing and providing on the part of the community is extremely important.

We would have benefitted greatly by a return visit by some sort of temporary clinic setting to see some of the questionable cases and save those people the expense of an unnecessary doctor appointment as well as to give the physical examiners the chance to review their own patients. I would think it a good idea to consider a schedule for the units to run something like it did this summer, but the second 4 weeks it could return to the first four communities to help with its own follow-up.

I was impressed by poverty in the mountains, but by wealth in Smithville and Murfreesboro. The poor people we did see there wore funny clothes but they sure knew how to play well. At least the kids did. I guess I was also impressed by a recurrent fear and/or distrust of government agencies on their part. We had to cut ties with them (government) to gain entrance to a family's home situation.

Follow-Up Questions

See Smithville-Murfreesboro report.

General Questions

There were not too many visiting dignitaries in Murfreesboro or Smithville, as I recall. The few who showed were put hard to work. My experience with them elsewhere was for the most part good but I think a lot of this goodness was because I was lucky enough to avoid the really bad ones.

It still seems early to evaluate what long-term effects the project will have on the medical profession establishment. I am not entirely pessimistic about it; too many people are talking about it. If we listened only to the Agencies (doctors, OEO, PHD, etc.), it would seem that we were disrupting things far too much. But the people we saw on home visits and the people I've met and talked with on various new Health Councils talked good about it. Although I may be over-reactive, it is exciting to me to see the potential begin to be realized of poor people in those communities to speak and act for themselves and begin to get what they really need on their own account. My peers: for some of them, the summer was a 3-month experience in a new environment; for some, however, it was a very real education whose effects will be I suspect very long range in giving new direction to their goals and

reaffirming the possibilities for real change through their own initiative. The project has proven to me and some others not only that students can handle real responsibility, but that they need to if a college and/or professional education is to be of value.

I think the first question the project posed was probably, what is the deal about fee-for-service? I started out fairly ignorant about advantages and disadvantages and problem areas in the medical profession. I was interested mostly in finding out what poverty was and if I could handle it (work with it) and still be happy. Perhaps the biggest question I have now is, can a liberal arts philosophy major recently graduated do anything of significance to change things, or is a "title" a necessity? I think I am going to want to return to school, not only for the title, but for the knowledge--law, medicine or teaching. I dread the thought of the classroom, when I consider how much more I learned out of it this summer. But it may make a difference now that I want to learn, instead of just having to.

Although I doubt that the statistics are very accurate, I would guess that even in their inaccuracy they would be helpful in pushing for reform in PHD procedures, grant proposals for local projects, and maybe even attracting students for next summer who might be interested in changing the numbers. The new Governor might be interested in how many rotten teeth we found, as might Dr. Fowinkle, but I should think the reporting of our findings to the local representative Health Councils so that they can see where their most prevalent problems are would bring about the most effective change, in many ways.

Functions

To set the stage for an experiment in quality rural health care delivery in Tennessee.

Additional Personnel

I felt a need, in our follow-up work in Smithville-Murfreesboro as well as elsewhere, for better help in cutting government redtape and more education in how most tactfully and least painfully to evaluate a family's financial/medical/educational situation. Maybe working with medical sociologists or more closely with Peabody during orientation will help.

I also wish we could have had better facilities for medical consultations than we did. As it was, we took all questionable

charts to Dr. Moss on the weekends. I hope some arrangements for a short-term "return clinic" can be made in communities where a full-scale Fair is put on.

Changes

I think I would dissolve entirely everything connected with the PHD and the AMA (except Dr. Christie) and start all over again with Sister Martha as the new directoress of a new non-organization called People's Health Coalition.

Personal Evaluation

Peggy Ingram

Job: Nurse and follow-up for Clairfield, Tennessee, from June 18, 1970 - August 21, 1970 with the Student Coalition for Community Health.

In the evaluation of my experience this summer, I feel it appropriate to include an evaluation of all activities concerning the job prior to and following my stay in Clairfield, beginning with the classes for nurses which began April 2. I believe the initial instruction began by Dr. Christie on physical diagnosis should have been furthered and practiced a good deal more in the spring. The series of Home Nursing classes were good in some respects. Senior and junior nurses had learned most of this, but most was good review. It was good especially for sophomore nurses, I thought. The class on first aid was by far the best, and one that we all needed. Dr. Goss' participation through instruction on labor and delivery was geared more to the sophomore nurse also; moreover, I do not believe was applicable in any areas. This was not the fault of the project; the number of prenatals in most areas was small or were seeing doctors during their pregnancy. This also applied to Mrs. Dunnaway's classes. This gear toward prenatals was not necessary and the classes could be used for further pursuit of physical diagnosis, community work, and first aid perhaps. I also think if perhaps there are a large number of sophomore nurses, a special group of classes should be held with them. At this time it would probably be beneficial to meet with nurses from this year's project to discuss expectations, duties, and general ideas.

I do not feel that a visit to the area in which one works is imperative. I think books such as Yesterday's People and Night Comes to the Cumberlands should be stressed as these offer an excellent picture of the area and a specific insight to the culture.

In my opinion, if classes and experiences could be planned for the spring--if personnel could be chosen earlier--then perhaps the first two weeks in June could be used for all project members to get a chance to know each other. I feel that not knowing the people we were working with was the greatest fault. I personally did not even know who was working in the project until the unit came to Clairfield and even then I just met many of them. This

was not the fault of the project, but I did think that knowing some of the people we eventually worked with or hear would have facilitated matters. Perhaps something could be planned where we could live together and be able to talk together and at least form some common ideas and goals. As it turned out, few of our goals were consistent and this resulted in personality conflicts as well as a lack of concern for the project in general. Plans should be made now for a schedule to be made for spring by January. In this way, people can be hired and plan to spend time in the spring with extra classes and meetings. Likewise, time should be allowed between the end of school and the beginning of summer for people to get away and be able to come back for a freshstart. One cannot push the project until all enthusiasm dwindles to complete drudgery. In many cases, I believe the lack of communication caused this to happen. I also think that at the orientation time, certain weekends should be scheduled for meetings together. I do not think every weekend is necessary unless groups so choose. But some weekends should be designated for meetings and places should be tentatively set up if possible. I think these meetings do provide a certain unity to the group and can be useful to the project, but they must be set up and dates given if possible because communic ation between some of these areas was rather hard.

As to my particular job in Clairfield, I was very pleased with my experience in general. This area wasset up insofar as health care planning was concerned. The Health Council had planned and built the clinic and is presently paying two employees. As we were invited by this group to come to Clairfield, we considered our contacts to come from this group. However, we found this not to be true and did have to go through other means to plan as well as carry out the Health Fair. The Health group was accepted by the community in general and the use of the clinic was a good example of this. I believe this group did work somewhat with the law students. The medical personnel were not contacted, consulted or questioned all summer as to our activities or duties. We were generally on our own to help where the clinic staff needed us. Housing was taken care of also by the clinic staff. I believe the medical personnel, consisting of two senior nursing students and one fourth year medical student, were easily accepted by the community. Health seems to be an important subject to many of these people; therefore, anyone connected with a medical team was welcome, this meant into the clinic as well as their homes. The main conflict was among us from the project as to what our goals exactly were. We had never gotten together on what we considered our objectives--which could have easily been done during

orientation, if all had been present or interested. We had problems as to whether we were there only to staff the clinic or to be concerned with the Health Fair and its follow through. This should have been straight before our arrival to Clairfield; however, this did not arise in importance until the end of July when we were all really needed.

The Health Fairs were generally accepted well by the community and proved to be beneficial as permanent records on file. Dr. Kirkpatrick expressed his praise and approval of the work of the project in general and also the Health Fairs and the records he has available now. As he is the main doctor for this area and the main receiver of most of the records, I think this is a high compliment to our work.

The medical services available to the indigent were not plentiful by any means. The county seat of Claiborne County being in Tazewell, which is across the mountain, created problems of transportation as well as communication. I was able to get some children under Sight Conservation Service for glasses, some children under the dental school program, and one under Crippled Children's Service. There were outlets for children's care, and the weekly visits of Dr. Moss facilitated and increased the care that was necessary for children particularly as a dentist will begin coming to Clairfield Clinic September 4 and from then on every Friday from 12:30-5:00, the need for a regular dentist in the area was partially met. He can see both children and adults and, therefore, provide one of the most needed types of medical care in the area. I did contact the head of the UT Speech and Hearing Center in Knoxville for possible aid in further testing for hearing and hearing aids. I did leave this with the clinic to follow through on his reply. By some chance of fortune, an eye doctor was coming to Frakes, Kentucky on October 2, 3, 4, 6, 7 to test and fit patients for glasses free of charge. By making appointments and contacting Frakes, I was able to make this available to Clairfield. Most of the rest of the follow-up concerned checking to see that people went to see their doctors. Clairfield was perhaps at the best advantage of the rest of the areas in that resources were right there and available if a little pressure was applied to the right persons. Overall follow-up in Clairfield went well.

Ann Baile helped tremendously with her knowledge of organizing follow-up. However, if we had been taught the mechanics of organization and what was necessary, we in Clairfield could have done the job of follow-up without her, perhaps. But as it was her knowledge was essential and the only guidelines we had.

As I said before and repeat for emphasis, the main apparent problem among the Clairfield personnel was the lack of unity and common goals. I think, perhaps, only one nursing student is necessary and she will benefit tremendously from the experience. Moreover, if the clinic remains in its same position next year, a medical student proves valuable in this situation. It is an excellent learning situation for him and likewise is helpful to the clinic. The position and tasks of the law students in the area was never clearly outlined to me. I cannot judge their effect on the community as I am not quite sure I know just what they did. This was a problem from the beginning and a lack of communication and association increased this.

The Mobile Unit most likely would not need to come to Clairfield next year. Moreoever, if it does come to a nearby area such as White Oak or Habersham it would be close enough to be available to Clairfield. Many of the people in this area now have a regular doctor so to speak, i.e. Dr. Kirkpatrick. With Sister Martha and Sister Margaret, many of their health care needs can be met.

Concerning the "dignitaries" ushered around the clinic, I can honestly say there were quite a few. I know Sister Martha appreciates the interest of the Vanderbilt group and she is not one to turn down any good that might come out of one of the many meetings. However, I believe more consideration of her time and perhaps notifying her before visits would have helped in planning her time. Many of the doctors were very helpful and were "put to work" when they entered the clinic. However, many who came to talk did not seem all necessary--although I also agree if something good came out of all the visits, they were worth while. Even so, one should not take advantage of a person's generosity.

I do think the project proved something, if not to the receivers but to the participants of the project. I, perhaps, was one of the luckier ones who had the advantage of being able to live with a family all summer, work in a community clinic, and participate in the Health Fair. People from the community were very appreciative of our efforts and were not afraid to express this verbally. The doctors (local) that I met (Dr. Kirkpatrick, Dr. Prater!) were very impressed with our work and seemed to accept us readily. Vanderbilt was given a new respect as many of the people in Clairfield now speak of Vanderbilt frequently.

I think the addition of medical sociologists would be beneficial to the project. In my opinion they could replace law students and incorporate follow-up people and medical people.

I do not want to pursue a discussion of my opinion of rural health care delivery. At the moment I have postulated many ideas but the discussion of them might show that have not as yet formed any definite objectives.

I personally enjoyed my summer very much. I did not change my ideals or personality drastically by any means, but I did leave with a wider awareness of human beings and many of their problems. I can now see the struggle many have to live day by day and the many blockades and impediments which have been created to hinder their progress. These impediments frequently turn out to be another human being who lacks this awareness of others.

Personal Evaluation
Carolyn Klyce and Dick Burr

Report on Deer Lodge

Carolyn Klyce

Our goal was to create an opportunity for low income people to control a project which could have a direct and beneficial effect on their lives. This was accomplished for the Health Fair itself--further action is in a stage of tentative planning.

PHASE I Getting Out from Under the Control of the Power Structure

The Health Fair was invited into Morgan County by a group called the Morgan County Comprehensive Health Care Planning Commission. This organization consisted of the thirty to forty people who comprised the upper strata of Morgan County. The commission was called into being by Mr. Tom Finley, an educational assistant public health officer who covers sixteen counties. The group met once for a discussion of the Health Fair, and has not met since. (Tom Finley is the only one who can call a meeting--it has no officers. Tom's idea was to get all the power people into a circle where they could fight it out and maybe come to understand each other as individuals). All accounts of that one meeting are rather muddled, but it seems that the responsibility for the Health Fair was palmed off on Mr. Charles Jansch, the county agricultural extension agent, and he in turn palmed it off on his Deer Lodge Home Demonstration Club. The Home Demonstration Club is a group of middle class, civic-minded ladies who comprise the upper strata of Deer Lodge. Because this group of ladies had a rather snobbish attitude toward the low income people of the community, and because Mr. Jansch has a reputation for doing little work and taking a lot of credit, we decided it would be best if these people did not sponsor the Health Fair. So we began to talk about low income people doing the planning and decision-making for the Health Fair, and the Home Demonstration Club decided not to sponsor us. (There were also some personality conflicts involved, but they arose within the politics of the situation).

PHASE II Getting Together a Low Income Organization

With Phase I accomplished, we spent all our time visiting with low income families--just talking, telling them about our Health Fair, and inviting them to community meetings about the fair. (We worked in seven different communities in the western half of the county: Deer Lodge, Chestnut Ridge, Sunbright, Burrville, Gatewood Ford, Plateau, and Lancing.) Chestnut Ridge and

Plateau already had strong grassroots organizations--Chestnut Ridge being community minded and fairly prosperous, Plateau being poor and somewhat iconoclastic, due to a very bad experience with the OEO. In the other communities, we called meetings at the school, church or community center. The people then elected a representative who would call future meetings, organize the work, and attend meetings of all the representatives. (Dick worked in Plateau, Lancing, Deer Lodge and Burrville; I worked in Sunbright, Gatewood Ford and Chestnut Ridge). Deer Lodge developed the strongest organization, owing to the work of Mrs. Harriet Hawn, its representative. Sunbright was a real failure in terms of organization--no one attended the meetings despite many days of visiting there. To me, Sunbright seemed to be comparatively large and fragmented. There were six or seven separate geographical areas in it, and the low income people from one area did not seem to know people in the other areas. One area in particular, Pea Ridge, seemed like the beginnings of a real slum--there were few gardens, and the poor people lived largely on welfare checks. By contrast, in most of the other poor areas where I worked, the people relied on subsistence agriculture for their living. There is a good deal of pride and self-reliance in people who can make ends meet with the work of their own hands. For instance, Gatewood Ford is considered to be a very poor area, where there is virtually no civic minded community leadership. It is virtually ignored by the power structure. But the people who live there are really fine.

PHASE III The Health Fair

All the communities shared the burden of feeding and housing the people on the mobile unit. They worked out these problems and supplied workers for all the jobs in the Fair (taking case histories, etc.). I think that the participation was superb, and the people who worked had a solid sense of accomplishment. Several helped us with the paper work on the charts following the Fair. One of our goals was to present the county with the image of low-income people successfully executing a project like the Health Fair so that everyone's concept of the capabilities of the poor would be altered. Some people saw and understood, but, of course, the full impact cannot be measured.

PHASE IV Follow-Up

Morgan County does not have a doctor or a hospital. Its residents must rely on the resources of surrounding counties. This is a very bad situation for emergencies--it is common for people not to be able to locate a doctor after 5 pm, no matter what the problem. A SAMA student working in Oneida told me that people have been allowed to die in the emergency room of the Scott County Hospital

because only one doctor will answer emergency calls, and if he is not available, tough luck. However, I do think that people in Morgan County have access to better medical care than do the residents of Sneedville, where there is only one corrupt and bad doctor who takes care of everybody. There are some really good general practitioners around Morgan County, like Dr. Allred in Jamestown and Dr. Collins in Monterey, and Oak Ridge and Knoxville are nearby.

Most people in Morgan County think that they need a full-time G.P. I do not agree. The doctors around Morgan County know that they do not practice the kind of medicine they should--they have too many people to take care of. If a doctor sees 130 patients in one day, he can do little more than treat the specific complaint. One entrenched pattern is described by a job, "You tell the doc what's wrong with you, and he treats it." Very, very few people ever have a complete physical examination which could detect a suspicious lump in the breast, etc. This is why I think the Health Fair was medically beneficial, and why I think Deer Lodge needs a screening and referral clinic.

The Public Health Clinic in Wartburg is not a very busy place. The public health nurse for our part of the county is a very sweet person who knows the people and cares about them, but who has a limited concept of her role. (This could be due to the influence of her supervisor, Johnny Malone. However, Mrs. Arrowood, the Morgan County nurse, has been very cooperative in helping with the follow-up). Public health has a missionary zeal in promoting family planning. Any poor person who has nine kids and wants one more is considered to be mentally retarded. They also do immunizations, chest x-rays, and home visits to check blood pressures and to refer the patient to his private physician.

The Welfare Department was quite cooperative with us. They stationed one of their workers at the Health Fair each day to take applications. The department seems to be honestly run, and with some understanding of the problems of low income people in the area. I was pleasantly surprised.

Our experience with the OEO was what really opened my eyes and changed my political views. To see such corruption in the face of such urgent need is the basis for radicalization. The county is so poor that any money coming in is the object of fierce competition. However, the competition is only over into which pocket in the power structure the money goes, not over who can use it to the best advantage of the poor. Food vouchers have been used to buy votes; a funded program to serve hot lunches to children at the Deer Lodge Community Center during the summer

simply does not exist--who knows where the money goes? The crowning touch came when I realized that "the-man-behind-the-scenes" in OEO is also Albert Gore's campaign manager in Morgan County. If Albert Gore, my used-to-be hero, is elected, it will be by the mechanism which keeps the poor in their poverty. I've often felt like Diogenes, looking for an honest man.

PHASE V The United Health Committee

The health group which formed around the Fair (the United Health Committee) is now thinking about getting a clinic. They have the familiar problems of dealing with factions, etc. We have begun talking to them about county politics, and who is against whom. Example: "The county school system has a dental program for kids. Half of the money is put up by the county, half by the state. The program takes care of only ninety children out of the whole county. Now we all know that money in this county goes into places where it's not supposed to go. It should go to help your kids. Maybe we could start asking some questions about it."

Everybody knows that the county is crooked. But no one man is strong enough to realize, "It's them against me. I'm the victim." I think that is why it is so important for people to cherish the illusion that they are free men in a free country. To think otherwise is to see yourself alone in opposition to something which seems far more powerful than yourself. Perhaps if the victims came together in a group, they could find the strength of opposition. This is my hope for the future of our health group.

Report on Meaning of Deer Lodge

Dick Burr

Living in Morgan County this summer, we found a significant social attitude in some people. For the most part, people saw each other on an equal level and were able to deal with each other out of strength. Though this led to conflicts and many divisions, these people seldom tried to exploit each other. The differences in strength were not great enough to allow one person to exploit another. Some people in the county, however, people who control or make decisions about the money flowing into the county from the state and federal governments, do not see and are not seen on an equal level of strength. These people exploit the others in the county, and the others in the county allow themselves to be exploited.

Because of this, many people in the county have an ambivalent attitude towards other people. They deal actively and strongly with some, and they deal passively and submissively with others. Because they deal submissively with some people, many of the people in Morgan County are exploited; they are held to a subsistence life style and are trapped in a favor system that makes them more dependent upon providers for auto parts, food, medical supplies, etc.

Trying to deal with this attitude, we carried out the activities that Carolyn has described above. At present, we are trying to help the United Health Committee gain the "strength to oppose." Our role with this group has a hierarchy of strengths to develop to the extent that one or two people control and are allowed to control the policies and activities of the committee. We must keep the distance between the members of the committee at a minimum. Second, we must continue to point out that the favor system benefits only those who they allow to initiate and control the favor system. Third, we must encourage the committee to do things to improve community health, for real activity will also build their strength. As the committee acts, the conflict between them and the exploiters will also grow, so they must be strong enough to push the conflict that will expose and eventually overcome the exploiters.

Along this direction, three suggestions for the future are in order.

The first is that we, medical and non-medical people alike, must be responsible for reducing the distance between the medical profession and the people. If people understand that the medical profession is at their fingertips and not on a pedestal, they will seize the initiative in building better health--the medical profession has them in the same position as the county exploiters. We must change this, however. People must realize that they are the ones who really improve community health and that the medical profession provides only one means of improving community health. Counterproductive to this was the attitude of some medical people during our health fair. Medical people must be willing to share in the vitality and interests of the community if they are to help the community build better health. Sharing in home life, social gatherings like church or square dancing or singing, and in the work of people living in the area are ways of doing this.

Another suggestion is that we train local people to do the jobs that we perform. In this way, the people can do more than simply think of things to do. They can actually do them. A serious part of our continuing program should be training in

in practical nursing, first aid, family planning, sanitation, community organizing, and medical follow-up ("how to deal with help - bureaucracies"). Again, this builds the group's capacity to do the things that will create conflict and gives it the strength to push the conflict.

Finally, if the community and the project can grow sufficiently, we can set up some sort of model health care system in Morgan County. Morgan County is in a perfect situation for the development of a network of screening clinics that could feed nearby hospitals and doctors. Five screening clinics - one each in Chestnut Ridge, Sunbright, Petros, Coalfield, and Wartburg - could feed hospitals and doctors within a half hour's drive. Each clinic could be heavily staffed by local people that we have helped to train, and could be administered by the United Health Committee. Through heavy publicity, everyone in Morgan County could know of the availability, extent of medical services, and the efficient referral service that the clinics could offer.

Having worked out and set up this sytem in Morgan County, the United Health Committee could begin to deal with the other health problems common to American social, economic, and political relations.

Follow-Up Report - White Oak, Tennessee

Kathleen Brewer

Leadership. Leadership in White Oak is not limited to a dynastic family, though several families have a history of community involvement. Leadership--or initial organized groups--reside in the churches; as far as I can tell, White Oak Baptist Church and the Church of God "contend" for leadership positions. I say this because 1) opposition to the Health Fair came from the Little White Oak Baptist Church; and 2) because we discovered that most of the members of the Health Council belonged to the Church of God.

Big families in White Oak are the Malicoats (brothers attend different churches, however), the Marlowes, the Wests, and the Huddlestons.

The Health Council. A strong health group exists in White Oak. It has a president, Fred Haynes, a secretary, Genevee Marlowe, and a treasurer. The group had already existed for a year and was selling used clothing (Lassie Malicoat) to make money for the treasury. The group has a "membership" (by attendance) of some twenty or so people at a given meeting. There are several outspoken members of the group: Haynes, Shirley Bragg, George King, Hiram Malicoat. Others sit back, but attend regularly.

At the beginning of the summer, the group had already been planning for a clinic, and had gotten some land promised for an annual lease of $1. Local people had volunteered the foundation and wiring work. A prefab house, donated, had been arranged by Marie Cirillo. The incorporation of the group was also underway. The group seemed to be eager but apprehensive about undertaking the clinic project and glad that the "health fair" was upon them. My impression is that they needed a health fair, something that they as a group could accomplish and wrap up as an achievement.

There was much community participation in the White Oak health fair. No one EVER signed a list as being "in charge of" food or housing or transportation--a great frustration to our meeting-minds--yet everyone was fed, housed, and transported. Men stayed around all day to help take people to and from the fair (Miss Reba Davis, OEO, had secured money for gas); Lassie Malicoat got local women to contribute food for the staff (but used some OEO Emergency Food money, which the staff viewed as definitely taboo).

During the summer, the group received its incorporation papers. Using money from a RMP project of Marie Cirillo's, the

group hired Wanda Marlowe as medical secretary for the Health Council, who assisted with the follow-up and who will be secretary when the clinic is built. Jane Evins worked with the group regarding the writing of by-laws, though there were none yet when we left the area. Charles Schiff was training Mike Ridenour and Bobby Davis in the testing of water, but the organized status of that project is unknown.

My own input into the project, unlike that of Charles and Jane, was entirely non-specific. It consisted of general encouragement, trying to plant ideas in the group concerning follow-up and the group's continued obligation to health care in the valley AFTER the health fair, and broadening the membership of the group beyond the confines of its present status. I feel that I learned no new tactics in the community work; rather, I adapted and used my previous experience. It is possible that, though encouragement and overview is important, people with specific skills suited to the community's needs are what will be best for follow-up next year.

At the close of the summer, the health group was planning on receiving a 12' x 60' trailer from LaFollete, free, for clinic use. The owner of Balloff's department store and his brother contributed this trailer and will do more, regarding the White Oak Council. The land for the clinic has been cleared. Some old equipment from the Vanderbilt Hospital--some of it useable--has been transported to White Oak and stored, and drugs left over from the mobile unit also have been saved. A Dr. Gerber, from Vanderbilt, has pledged one day a month at the clinic. It seems that the need of the group at present is receiving funding on a larger sclae--for equipment and a salary for continuing nurses and doctors.

Reception by the Community. The entrance of the follow-up people into the White Oak community provided the only measurable hostility manifested toward the group all summer. Though the staff had made careful amenities concerning dress, language and conduct, we were nonetheless "outsiders" of college age and lumped together with the students from the Divinity School's "folk school" as being hippies. Opposition and fear that we were communists grew; the woman who was kind enough to keep us was so intimidated by the congregation of the Little White Oak Baptist Church that she had to ask us to leave her home. There were two occasions, during that same few days, when a group of men attempted to disrupt the Health Council meetings. On Wednesday of that week, the

office building of Marie Cirillo (a Catholic health organizer) burned to the ground: the fire was uninvestigated.

Many of the community banded together in our defense. We became a sort of tangible symbol of their strivings as a health council ("Should we leave White Oak?" I ask S.B. "No, nobody's going to keep us from having our health fair."). We immediately began a door-to-door campaign, introducing ourselves to the White Oak residents and disaffiliating ourselves from the folk school. There was, as far as we could tell, little hostility once it was known who we were. Even so, those who had initially opposed us, save one, did not come to the health fair.

Working Relations. Charles and Jane and I, all being of vastly differing temperament, worked amazingly well together. The struggle for transportation put some tensions between us, as we all had to use Jane's car. Other tensions arose out of Charles' tendency to be late and my own feeling that he was "not political enough" for the job. Likewise, I was the "organization woman," probably irritating to Charles.

Both Jane and Charles were great in community relations. They were readily beloved by the community. Charles and I usually worked together, in initially preparing for the health fair and in making visits. Jane, however, did a great deal of visiting on her own and handled many important details of the fair. During the actual medical follow-up work, Charles punted and Jane and I ended up doing much of the paperwork drudgery. Eventually, Jane severed herself from follow-up to wind up her legal work; and Ann Baile and I finished up the follow-up work and handled the Habersham, Elk Valley, and Kentucky Hill fairs and follow-up. Charles continued to work on the water and also did a creditable amount of work on the dental equipment in Clairfield.

(NOTE: See Ann Baile's write-up of the satellite health fairs in Kentucky Hill and Elk Valley.)

County Medical Services. For indigent populations without a medical card, about the only health services they can expect come from the Public Health Department in Jacksboro, Tennessee. Some of the people in Campbell County, close enough to the Claiborne County line, can attend the Clairfield Clinic, and do, though such practice is discouraged.

For those with medical cards or needing a doctor, Jellico is closest. Dr. Prater is the only practicing physician in Jellico, except for a Dr. Watts, retired, and a Dr. Fox, a

hopeless drug addict. Dr. Prater owns and runs a private hospital, run on a fee-for-service basis. It is constantly overrun with patients from rural areas; he has been known to see six patients in 10 minutes. There is a hospital in Jellico, newly constructed and fully equipped, awaiting staffing and funding. At present, the populace is becoming aroused to the point of demanding the opening of this hospital.

Lafollette, Tennessee, also has several doctors. Drs. Wood and Crutchfield, surgeons, practice there (and are overrun); also Drs. Roscoe and John Pryse, Dr. Sargent, and one or two others. Lafollette is somewhat farther from the White Oak area than Jellico.

Dental care in Campbell County is non-existent, save for a once-a-month dental day at the health department. Title I money in the schools, used for dental care, is about the only means to such in the area. Those above or below school age are left out of even this.

My feelings toward the public health department changed during the summer. I began highly skeptical about their competence and their concern for socio-political causes of bad health ("Do you have any sort of program for malnutrition?" "Well, there's a food stamp office.") However, when we began following some of our community people with bad lungs, possible TB, et al, the nurses were more than willing to take them on as cases and did so immediately. My conclusions about the health department personnel are thus ambiguous at present, though I can unequivocably state that the health department is hopelessly entangled in bureaucratic red tape and pathetic scheduling that often runs counter to the good health of its visitants.

In forecasting health care in the Valley and in the county, I would suggest:

COUNTY: A series of mobile units, containing x-ray, dental, and examining workrooms, to travel at regular and frequent intervals throughout mountain communities. One unit would have no function as an outpatient clinic. It's like getting the entire public health department mobilized.

Emergency transportation to hospitals, etc., should be provided by a helicopter.

VALLEY: The Ad Hoc Committee for the Model Valley seems to be working toward good health care for the area. A survey of

of health needs has been conducted, and I suppose that funding for several well-placed clinics in the area will soon be sought. In this, the people themselves, informed and armed with facts re their own health needs, could pretty much run the show.

The two above concepts are entirely independent of each other; how they dovetail, I'm not quite sure.

Public Assistance: Most people in the White Oak area are on some form of public assistance. Social Security, Disability, and Unemployment Insurance are the most widely used programs. Many men are now qualifying for the black lung benefits. There is a great pride in still being able to work--and a man with a job is a rarity, both admired and envied, and somewhat resented.

With pressure, the welfare people are cooperative. Cade Sexton, in Jacksboro, professed great concern for our project and the needs it would uncover; I, however, did much more poorly than Jane, a law student, in wrangling benefits for residents.

Function of the Groups. The medical students certainly performed medical tasks this summer. Often, however, I felt that they were too busy to really take time with a patient and adequately perform the counseling portion of a physical examination.

Nurses worked as nurses and as practitioners. They can best evaluate the success of their program.

The accountant, though he handled his books, also handled the blood work and the x-ray, I think, on pressed days. There is a certain herosim to "getting the work done, no matter what"... yet I hesitate when I consider the quality of the work we administered under pressed circumstances.

Follow-up students functioned as community organizers, secretaries (when the folders came back).

Secretarial workers functioned as shot-givers (alas) and as general flunkies. My concern here, regarding good medical treatment, remains the same as above.

Law students functioned in some cases as follow-up workers. Aside from that, their function is beyond me.

Law Students' Evaluation

The following is a moredetailed report of the work the law students did during the summer. It includes an account of problems, resources, and recommendations for change in each of the main areas of their project: Mobile Unit, Clairfield-White Oak, and Briceville. Because of its length, it has been separated from the main body of their summary which appears earlier.

Mobile Unit

A. Operational

Generally, the daily operation of the mobile unit proceeded well. Bottlenecks and other mechanical problems occurred, as they will, especially in the early stages of the week, but were effectively remedied in most instances. Some health fairs proceeded more smoothly than others, a circumstance attributable to the quality of volunteers. We had little control, beyond the routing system, over the operational success of the mobile unit because of our necessary dependence on the volunteers. The cooperation we received from local superintendents of schools varied with each community but was generally adequate.

More sensitive consideration was deserving our own personnel regarding the length of working hours and free time. Our personnel were most willing to do as much and more as was asked of them. Much personal sacrifice, measured in mental and physical fatigue, was expended for the success of the project. Many individuals who signed on and expected to perform specific tasks wound up in jobs with which they were totally unfamiliar and untrained.

But they learned and adapted quickly because it was required. However, there is a physical and emotional threshhold beyond which an individual ceases to function effectively. The natural result of long hours, large numbers and disorientation to task and environment is a psychological pressure and strain whose intensity is unique to each individual.

As the summer progressed, the call of meetings, so essential during the first few weeks of initial adjustment, continued with constant regularity and, thus,

proved to be a continuing source of annoyance. Generally, the meetings were inapposite to the group assembled as a whole. Smaller, more informal meetings, comprised of people whose presence was essential, would have been more effective and productive.

B. Functional

The mobile unit itself, and its weekly health fair, functioned as the focal point of the project. The health fairs were the keys of entrance for our personnel into the local communities to publicize and arrange for the mobile unit's arrival and, upon its departure, to remain and follow up. It is questionable whether the central thrust of the project should be directed toward the mobile unit's activity.

It is suggested that any future project emphasize community activity and involvement beyond the level apparent this summer. Of course, within a summer's time it is difficult to gain acceptance into a community, assess its problem areas and effectively remedy its infirmities. However, if the number of fairs were reduced by half, 4 locations were discriminately selected, and if the length of the fairs was increased from a week to ten days, such a shift in emphasis from the unit to the community could be accomplished. The location of more people in the community, more extensive preparation, more relaxed follow-up and, perhaps more local involvement would be consequent. The mobile unit still would function of necessity as the diagnostic center and teaching lab. But its role at the hub around which all else in the project revolves would diminish or extinguish in favor of the community.

C. Law Students' Role

Two law students located with mobile unit during most health fairs. Nominally, our role was legally oriented. In fact, our function was ill-defined and uncertain. Our activities were limited to advising and referring, primarily oriented toward the availability of health services. We had frequent contact with the various agencies to which we made referrals (e.g. welfare department, public health, Social Security). Prior to our first week, we had been led to believe that most of these governmental agencies would be hostile to our efforts and that they were working against the best interests of the people in their county. During the summer we had occasion to meet

and work with representatives of numerous agencies in several counties. We found most everyone cooperative and anxious to assist us in our efforts to help citizens in their county. After our initial visits (a visit to all agencies on the first day of each fair was our regular practice) several directors and workers visited the fair later in the week. They were always receptive to referrals made by us.

There were many people with adequate need for public assistance and/or medical care and much to our chagrin we could only advise them that no help was available. One category of indigent repeatedly turned up--widows between 50 and 60 years old. Typically, their children had grown and married so they were ineligible for AFDC. They were too young for OAA (age 65 for eligibility) or for survivors insurance under Social Security (age 60 for eligibility). They are in an age group which makes employment acutely difficult. They usually had physical difficulties, but not serious enough to qualify for assistance as "permanently and totally disabled."

Another recurring problem involved dental care and services. No assistance program exists to pay for dental care. Even those on Medicaid cannot receive dental services. This is particularly a problem with children. We saw many children who had lost half their teeth by age five, and some who had lost all their teeth by that age. This, of course, forces the permanent teeth in prematurely and creates dental problems for the full life of the individual. The only source available is a small fund of Head Start money which is used to treat the teeth of some of the children selected for that program. But this covers only an extremely small percentage of children.

The mobile unit was overstaffed with law students. Murfreesboro, where we experienced our heaviest workload, alarmed us to believe we would need two law students on the unit. Such an assessment on our part was ill-conceived. As our confidence grew with each week, it became apparent that we were wasting manpower, a situation we did not rectify until the last few weeks.

It is suggested that only one law student be assigned to the mobile unit in any future project and then not necessarily in a permanent capacity. There are several options available. The project's organizers may decide that a law student's presence is required full-time with the unit and that the long periods of inactivity are just

a consequence of the nature of the project and thus to be accepted. This option is undesirable from the standpoint of both the law student and the project. A second option would be to train the law student to perform other functions on the unit and provide legal advise as the need arose. This too is unsatisfactory since few jobs which the law student could perform lend themselves to frequent interruptions and long absences from work. The third option is to have the law student work part-time with the unit. He should be granted flexibility to come and go when and where needed. The pre-health fair publicity could announce the one or two days and times during the fair when the law student would be present. If legal problems arose on other days, they could be noted and he could visit the people seeking advice during his visit to the fair. He could be available to aid in follow-up once it commenced. If other law students locate in the four communities, they could devise a schedule to adequately service the unit during the health fair in their community. The handbook of rights and benefits written by this year's law students should be used as the basic reference book by law students on future projects.

Clairfield

A. Background

Of the three people placed in the Clear Fork Valley, two of them worked in the Clairfield area and one in White Oak, a small community on the mountain above the valley. As was mentioned earlier, this valley was the focus of our efforts because the nature of the human and organizational resources indicated we were likely to have more legal work to do there than in any other place. There was an established clinic staffed by nurses and visited weekly by a doctor, an OEO community center which housed the clinic, several citizen health councils, an active economic development council, and a valley-wide health survey for planning purposes being conducted by a community health professor from the University of Kentucky. The health survey was an effort of the local health councils to define the health needs of the people of the valley and was funded by the Ohio Valley Regional Medical Program.

Another important resource was a community development worker, supported by FOCIS (Federation of Communities in Service), who has helped start several community programs. This community worker, Marie Cirillo, was instrumental in getting the Robert F. Kennedy Memorial Foundation to send an economist to the valley for one year.

B. The Valley - A Description

It is typical Appalachian terrain--a narrow valley with many creeks and hollows which meander back this way and that until they find their end at either Cumberland or Pine Mountain. The Clear Fork River drains the valley which has very little arable land and precipitous side walls. Access is by steep twisting roads that curl over the mountains at both ends of the valley.

The valley covers two states, Kentucky and Tennessee, and four counties, Bell and Whitely in Kentucky, and Claiborne and Campbell in Tennessee. There are no incorporated towns in the valley which has an estimated population of about 6000-7000. The closest towns are Middlesboro, Kentucky, Tazewell, Jellico and LaFollete, Tennessee. Tennessee Route 90 runs through the valley and the Southern Railway maintains tracks into the valley.

In referring to the valley we speak of the Tennessee part which includes most of the valley. The division of the valley by the county line for Campbell and Claiborne Counties has a most pervasive effect on the people and their condition. Not only are there no municipalities in the valley, but also common valley-wide problems such as governmental services must be taken to separate county seats for resolution. This problem is compounded by the county line serving to divide not only the 2nd and 3rd Congressional Districts but the state senatorial and representative districts. Consequently, political and organizational power generated by the people suffers severely because of this political diffusion. Effective organization of the people of the valley is stymied by the division of their political interest and allegiance. Even those agencies which can consider the valley as a whole, the Appalachian Regional Commission and the East Tennessee Economic and Development District, operate ironically under the policy of serving urbanizing areas as a means of getting people to move out of such unservicable places as the Clear Fork Valley.

In the early 1950's the valley had a thriving economic life. The population was estimated to be around 13,000 and underground coal mines provided the major source of employment. There were several doctors in the valley and the Tennessee Medical Foundation started a clinic which lasted for a brief time in the mid-1950's. However, the mines started closing around 1955 and 1956 and the valley has known hard times ever since. The doctors have gone

along with over half of the boom-time population. The underground coal mines have been replaced by strip mining, which requires more capital but employs less people. There is one underground coal mine in the valley being operated by the Consolidated Coal Company, but it employs miners from LaFollette and Middlesboro, principally. Of the three major strip mine operators in the valley one is located in Clairfield and the other two are from Jellico and LaFollette. Jobs available on account of strip mines are driving coal trucks and heavy equipment. These jobs are filled mostly by young men, most of whom live in the valley.

The rest of the valley labor force consists of small merchants, marginal farmers, some small lumber mill operators, people who survive on odd jobs--welding, carpentry and the like, and people who commute to the hearby job center or the more distant northern job centers.

The problem of this last group are well known. They are the migratory industrial workers who would prefer to live in the mountain with their families but who work in Ohio and Michigan because of the lack of employment in Appalachia. Some commute on the weekends and others spend periodic blocks of time outside and then return for a variety of reasons. Those who commute to the regional employment center face the problems of extensive travel time over roads scarred with pot-holes and frequently impassable during the winter months. The havoc wreaked on automobiles by the poorly maintained roads defies description.

The environment of the valley is characterized by substandard, inadequate housing, no water systems, no waste disposal system of any kind, no fire protection, poorly maintained roads, polluted streams and water tables, and hillsides which are laid bare in the search for coal. Communication is provided by the U. S. mail, television, radio, and the party-line telephone which generally has eight parties on each line. There is no organized transportation system. Many people have automobiles but they are of questionable reliability, and those who do not have automobiles, mainly pensioners, must depend on friends or pay heavily from their fixed incomes. Health services are limited to the local clinic staffed by several nurse-practitioners and supported once a week by an internist from Middlesboro, Kentucky. The nearest hospital is about

thirty minutes drive from Clairfield, but it has limited services only. The closest large hospitals are 40-45 minutes away in LaFollette and Middlesboro.

Most people in the valley are served by electircity, though coal is the primary source of heat in the winter. A crisis of unknown dimension for everyone, and especially pensioners, is imminent this winter due to drastic price increases of both coal and electricity. Coal has risen from approximately $8-10/ton to $15/ton and local electric companies have been forced to pass along the TVA 23% rate hike to their consumers.

The character of the Clear Fork people and their institutions are highly important elements of this valley. Although we have no statistics, it is apparent from close observation that the valley is an economically depressed area. The young and the elderly both consumers and non-producers, seem to constitute the largest segiment of the population. Job opportunities and wage scales in the area are both low. The elderly are tied to fixed incomes of welfare and Social Security. The people who are unable to get welfare barely survive.

What then are the forces, the institutions, which keep people in the valley when jobs and much of the population have moved on? The church, the family, the poor education appear to be the primary resons. The church in the form of fundamentalist religions seems to breed a distrust of new and foreign influences, but is the strongest of weak community institutions. The experience of the students in White Oak which will be recounted later indicates the attitude of the churches.

The effect of cohesive and large family units is felt in efforts to organize communities. Since families are large and intricately interrelated, the reluctance of one branch may well receive the sympathetic reluctance of another branch of the family.

Poor education is self-explanatory. It limits job opportunities and seems to have a negative effect on the desire to organize into community groups.

Other institutions which exercise some control over the people are local merchants and the American Association, Ltd., a British land holding company which owns an unknown but substantial portion of the land in the valley. The local merchant who deals in food, clothing and fuel has

the power in his credit practices to dictate social and political allegiance. It is not coincidental that in the family of one local merchant there are these elected or appointed officials: a squire (member of the County Court) and Justice of the Peace, a school board member, a member of the equalization board, a member of the county planning commission, and the director of the local OEO community center. The American Association which has offices in Middlesboro casts an imperialistic cloud over the valley. This organization has extensive land holdings which are leased for the strip mining of coal. The effect of this method of extraction on the environment in terms of water pollution, destruction of the roads, drainage, and aesthetics is significant. A large stock of the housing in the valley is rented from this company. These houses, substandard and not maintained by the Americah Association, cost $8 to $15 a month. There are practically no leases and it is the express intent of the American Association to constructively evict its tenants. There is no alternative shelter in the valley and these people cannot afford mobile homes or houses due to present building costs and high interest rates. The American Association drains the valley's resources while impeding its development.

C. Services Available

The lack of services was noted in the description of the valley in the previous section. There being no municipalities in the valley, the burden of providing services is placed on the county court and the state. The county services include education, road maintenance and law enforcement. The county based state and federal programs include welfare, food stamps, Social Security, employment security, and OEO community programs.

Both counties maintain elementary schools in the valley and provide hot lunches through the federal school lung program. Supplemental programs funded by Title I of the Elementary and Secondary Education Act have been instituted in the schools. In what appears to be the only existing inter-county arrangement, all valley high school students use a regional high school.

The only law enforcement in the valley consists of a deputy sheriff in each county and two justics of peace in Claiborne County. These deputies operate with great freedom of discretion, and defeat of the incumbent sheriff appears to be the only control mechanism available to the people.

The counties provide minimal road maintenance in the valley. The secondary dirt roads are scraped and leveled periodically but the paved primary roads suffer severely from the weight of over-loaded coal trucks. Officers from the state Motor Vehicle Enforcement Division make quarterly appearances in the valley but choose only to penalize the over-weight trucks the difference between the cost of the license they should be carrying and the cost of the license they presently carry.

The county based state and federal programs are all well administered considering the geographical conditions. The only significant problems these agencies have is in their informational outreach to the valley people.

The valley suffers from its political fragmentation in terms of service from social agencies. While most federal programs are set up on a regional basis the state programs with county offices such as welfare, food stamps, employment security, and public health are not and the people undoubtedly suffer poorer service from these agencies. The food stamp program had been operated on a valley-wide basis by Campbell County but the failure of the state to allocate more workers to Campbell County forced a return to the old two county service system. The OEO community action program is another example of fragmented service.

There are no lawyers in Clairfield or the valley. Legal problems which involve the courts in any way must be taken to Tazewell, the Claiborne County seat, which is an hour and a half trip. There are supposed to be seven attorneys in Tazewell but some split their time between there and New Tazewell. We spoke with several attorneys and they expressed a distinct displeasure about taking cases in Clairfield because of time, distance and insignificance of the problems.

The only health care available in the valley is from two clinics--one in Clairfield and a recently opened one in White Oak. The clinics are staffed by Sisters from a Catholic nursing order and receive periodic visits from outside doctors. Jellico has two hospitals, only one of which is open. This hospital is operated by one doctor who has a provisional license and is not allowed to practice obstetrics. This doctor has been known to turn away Medicaid and Medicare patients.

The other hospital was built with Hill-Burton funds but has remained closed for over a year due to the lack of a professional staff. The Jellico Area Health Council, the group charged with the responsibility for opening the hospital, has been beset by inaction and political strife.

There are community hospitals in Tazewell and LaFollette and a private hospital operated by the Appalachian Regional Hospital Corp. in Middlesboro. All of these hospitals are at least 40-45 minutes away providing the weather and road conditions are good. The private hospital has a restrictive policy concerning charity patients. In addition, the valley has no ambulance or rescue service. All emergencies must be met with available transporation.

In a much broader sense, there are services available from regional agencies such as the Appalachian Regional Commission (ARC), the East Tennessee Economic and Development District (ETED), and the Tennessee Valley Authority (TVA). The general function of ARC and ETED is the creation of a favorable economic environment for the areas they serve. ARC serves all of Appalachia and ETED serves a sixteen county area which includes Claiborne and Campbell Counties. However, the policies followed by these groups appear to be inimical to the immediate interests of the people of the valley. Both of these agencies give practically exclusive attention to urbanizing areas and growth centers based on the idea of efficiency of providing service. There are, however, groups of people who will choose to live in the hollows and creeks and not give up their homes and land to accept better education, medical and social services not to mention steady employment. While ARC endeavors to bring these job centers closer to places like the valley by improving major highways, the neglect of the more rural communitis raises questions of equitable treatment by governmental bodies.

ETED follows the ARC policies on a more localized level and works mainly through the established political system. Their main emphasis appears to be on industrial development. They have offered advice, but little more, to the two local economic development groups which have formed in Clairfield and Habersham.

TVA is a vital force in East Tennessee but the Clear Fork Creek is not in the TVA drainage area, and consequently the valley receives very little of its services. The TVA has provided some assistance to the Clairfield Economic Development Council in their effort to build a wood palleting plant.

D. Method of Operation

The two law students who lived in the valley rented a house in Hamblintown for the summer. They were joined by

the family of a project doctor for part of the summer. Since both law students were married and one had a child, there was an identifiable family structure which the local people could see. The presence of married couples and a family unit appeared to dispel the suspicion of outsiders and imagined different moral values. We were unable to detect any distrust because of our age or our living arrangements.

We made contact with people primarily through the local health survey, the nurse at the local clinic, the health fair and work with the local economic development council. We received specific referrals from the health survey. The survey interviewers asked whether people had problems or questions associated with assistance programs and would they like a volunteer to call on them. If there were affirmative answers to both questions, and the interviewer could not answer the first, we would call on these people. We received referrals of the same nature from the local health clinic and, of course, we made direct contact with people who sought advice at the health fair.

Altogether we handled approximately fifty referrals in the valley with welfare, Medicare and black lung creating the most frequent problems. About two-thirds of the referrals involved no more than explaining benefits or application procedures, particularly with black lung inquiries. The other referrals required contact with agency offices and follow-up work with the people.

Our contact with people through the local economic development council was indirect since we worked on specific problems brought to us by Brady Deaton, the Robert F. Kennedy Fellow.

Other associations with the community came as a result of ordinary social intervourse, contacts made in and about the clinic, and working with the Little League baseball teams. We did not make any effort to join in the religious life of the people although this was a tact successfully employed in other locations.

In circumstances where we had to make inquiries with federal and state agencies in order to assist a local person, we were very much frustrated by goegraphic obstacles and the lack of facilities. We were unable to have a phone installed in our house due to engineering difficulties, even though we made application early in June. The office of the local economic development council was

destroyed by an apparently man-made fire during our first week in the valley. The only other phone we could use without seriously inconveniencing somebody belonged to the OEO community center. The lack of confidentiality limited our use of that phone.

Consequently, we had to conduct much of our business with the Welfare and Social Security agencies face to face. For our welfare problems in Claiborne County this meant an hour and a half trip across two mountains. As a result, we kept such trips to a minimum.

The inaccessibility to a full law library and the distance to the University of Tennessee Law Library prevented us from pursuing more theoretical research that we might have done on local problems. While such information might not have had immediate utility, it would have expanded our understanding and knowledge.

Another inhibiting factor was the brevity of our stay in the valley. We were heistant to follow some social and legal problems because the strictures of time prevented any satisfactory resolution. We felt it would be grossly unfair to urge people to exercise their legal rights and not be present when they needed advise as to further action or the assistance of an advocate.

E. Legal Problems Encountered

Because of the virtual unavailability of legal assistance in the valley and the other areas visited by the Student Health Coalition, law student members of the Coalition were called upon to deal with a wide variety of legal and quasi-legal problems. To subsume these problems in categories is perhaps the most efficient method of description, although it must be stressed that the diversity of factual problems defy neat categorization:

Health-Related Legal Problems - Although it is tempting to include all the encountered problems in this category, it will be restricted, for purposes of this report, to the actual problem of health-care delivery to our constituency. The most frequent legal structure we dealt with was Medicaid and Medicare. We served essentially an informational and expediting function by explaining the various programs to individuals and families requesting information. In addition to these two programs, we

were confronted with the maize of state and federal programs designed to provide supplemental health care, e.g. Crippled Children's Service. Included in this category was our advisory capacity to local health clinics who were vying for OEO funding.

Public Welfare - Perhaps the most common problems encountered were those relating to the various public assistance programs. We advised and directly worked with applications in cooperation with the County Welfare Directors to ensure full compliance with the applicable regulations.

Social Security - Aside from traditional Social Security problems, we were deeply involved with the new Federal Coal Mine Health and Safety Act or the Black Lung Law, which was administered by Social Security.

Criminal Justice - A few matters of criminal law were brought to us. These involved mainly arrests made during the time we were in the area. Necessarily, our function in these matters was limited.

Strip-Mining - We were constantly faced with the destruction wreaked by strip-mining in the areas. Aside from the direct defacement of the land, the damage visited upon the roads by the coal trucks was an area of constant concern.

Landlord-Tenant _ By far the most pressing legal problem in the area, the housing situation bordered on feudal legal concepts. The land was owned almost exclusively by a large English land holding company which rented substandard dwelling houses to many residents. No repairs were made on the houses, the landlord exercising total hegemony over the tenants.

Economic Development - We actively aided two local development corporations in their incorporation and loan procuring process.

The brief summaries above shed little light on the deep human suffering that was encountered. Our role as ombudsmen, although accomplishing little in the way of concrete reform, hopefully stimulated the clients we advised to greater heights of organization less bewildered by the confusing and inadequate laws that so harshly control their lives.

White Oak

A. General Comments/Background

For the duration of the 8 weeks, I was stationed in White Oak, Tennessee, in the Clear Fork Valley, a part of the "Model Valley." I lived during that time with a retired-coal-miner-and-part-time--Baptist-minister and his wife at their small, mountain farm home, thus being the only law student to be permanently situated with a local family. Two follow-up people lived in similar homes in the same general area; and, since those two had no means of transportation, my activities were, by circumstance, and partially by necessity, inextricably tied to the activities of those students. The combination of the two forementioned circumstances--the live-in arrangement plus the dependence of the follow-up people on me for transportation--along with the fact of my being a female law student combined to produce a summer experience which was personally pleasant enough but professionally rather unproductive.

White Oak is a small, unincorporated mountain community in Campbell County. There are three groceries, three gas station areas, one cafe, an elementary school, and many small churches. The nearest town is Jellico, some 15 miles down the mountain. Jacksboro is the county seat--it is 25-30 miles away, and LaFollette, about 20-25 miles. The leadership for the community's involvement with this summer's health effort emerged, largely, from the membership of one fairly moderate Baptist Church in the community. There is, of course, no formalized governmental structure in the community. Because there have been virtually no community involvement activities of note, there seemed to be no deep rooted aminosities or entrenched "political" divisions which could be detected. The strongest forces of divisiveness emerged, in connection with our health effort, from the churches. (A neighboring community's health clinic is run by a Catholic nurse and three public health nurses in the country are also Catholics: the fundamentalist churches of the White Oak area became suspicious of our involvement with putting on a health fair, thinking that we were some "Communist or Catholic conspiracy"...) There is virtually no industry in the area, the now largely defunct coal mines being the former source of employment of local people. There are two active mining operations being carried on presently, one of which is predominantly a strip mining outfit. The people, therefore, are economically, and consequently politically, powerless, one graphic illustration of which is the atrocious condition of the two black-top roads which attempt to serve as arteries of physical communication between the local people and the "outside."

B. Situations Which Provided Contacts for "Legal" Problems

1. Preparation for and Follow-Up after the Health Fair.

In working with the two undergraduate follow-up people who were initially concerned with helping the community health group organize and publicize the week-long Health Fair, a base of friendships and contacts was laid which proved profitable for me in establishing trust. I did not "publicize" the fact that my interest was law and, since I was associated with the other undergraduates, it did not become apparent to the local people that I was interested in counseling with them specifically about legal problems. We had thought that it would be best to de-emphasize the law aspect of our overall program, suspecting that there might be resentment on the part of the local people against "the law" and, in addition, that there might be a traditional distrust of lawyers. In retrospect, it seems to me that I might have been more satisfied with the overall results of the summer had I more quickly made it clear that, although I am "just a woman," I had other than social work aspirations in mind. However, realizing the shortness of my stay in the valley, perhaps it was best to establish a base as an interested person, then let whatever law training I had come into play in trying to solve whatever problems happened to be brought to me.

Specific law-related opportunities arose from my contact with the local health group which sponsored the health fair. The group had recently incorporated as a non-profit corporation and they asked me to look over their charter and then help them compose their By-Laws. Later, the group entered into a lease with a local mine owner and I was asked to help draw up the conditions of the lease and sit in with the local health group board members in their discussion of the terms with the lessor.

2. During the Health Fair Week

My role during the Health Fair turned out to be that of a coordinator. I did rotate with the two law students who were permanently attached to the mobile units, but the actual number of law-related problems which arose during the Health Fair was small. Several requests for making inquiries into the status of Black Lung applications with the Social Security Department were made; one father complained that his divorced wife was not properly caring for their two children and requested that we help him; several potential candidates for Welfare grants came to us for information; others whose medical problems had been uncovered during the Health Fair medical screening wanted to see what attention they could get under existing medical aid programs; some had had problems with mine union welfare and retirement funds.

3. The Health Survey being conducted in the area.

Several referrals were made to me as a result of a health survey being conducted in the area by the University of Kentucky Department of Community Medicine under an independent planning grant. Local people interviewed people in their communities, and, if the interviewer found that the person being interviewed wanted to talk further with "a volunteer" about some specific medical-legal problem, the law students in that particular area were contacted. Most of the calls I made as a result of that survey dealt with persons who, eventually, qualified for welfare assistance or who had some lack of communication with the Social Security Department about benefits. Several requests for help in securing eye glasses were made, although no source of help was found.

4. Contacts made by virtue of my living arrangement

The people I lived with are held in high esteem by the community. Once I was taken into the house, a trust-by-association seemed to become attached to me. Several people came by to seek me out and confide in me; others called and asked me to come to their homes to discuss a problem. Generally, the "legal help" given consisted of writing a letter in someone's behalf, making some phone calls, taking someone to an appropriate agency or office and helping him articulate his position there, or merely advising someone about what courses he might pursue himself. The problems included food stamps; Black Lung applications; Social Security payments not being paid in by an employer thus disqualifying a worker who had relied on his employer's deductions from his salary as evidence that the proper payments had been made; divorce; a son's court martial; posting bond in a foreign county; and insurance premiums which had "mysteriously" been raised. Other questions were asked of me in indirect ways; and I offered "answers" to other "questions" which were never verbalized but which arose by virtue of circumstances which I came in contact with.

C. Services Available

1. Locally

The "vital services" available to White Oak consist of the U.S. mail, telephone service (8 party lines), electricity, and a local elementary school which has hot lunch programs most of the time. There is no water system, no garbage or trash collection (dumping along the roads, into the creeks is the "system"), no sewerage system; there is no doctor (although one comes once a week to a nearby clinic in another county) and there is no lawyer.

2. County based federal and state agencies of service.

a. The Welfare Department, which administers food stamps at various regions in the county, but not in White Oak, is located in the county seat, some 25-30 miles away. The head of the department is a local man who is most sympathetic to the needs of the county people and was most cooperative with me. His staff, likewise, appeared to be helpful. The chief problem with the administration of this department in a mountain area, however, is illiteracy and lack of transportation: people do not write in for help and they cannot get to the county seat or, often, even to a telephone to get help.

b. The Social Security Department has a branch office in LaFollette. The same problems exist here, too--no out reach to the cut-off people.

c. Department of Employment Security also has a branch office in LaFollette. In addition to the transportation problem, the problem with this service is that there is no employment available in the White Oak area, so the compensatory services of this department are often moot.

d. OEO-North Cumberland Community Action Program: a well-intentioned but politically ham-strung organization which cannot effectively serve the area people until it cleans its own house. Office located in LaFollette.

e. Vocational Rehabilitation--sends a man into the county once or twice a month, when there is a reason. Interviews are held at the LaFollette Department of Employment Security. A trip to LaFollette may permit an interview if the man from Knoxville happens to get there or if you have made a long-distance call to Knoxville to make a definite arrangement with him.

f. The OEO operated Emergency Food and Medical Program is efficiently and humanely run out of the county seat. The program is not designed for long range assistance, of course.

3. Legal Services

There are no lawyers in or very near White Oak. There are 13 lawyers in all of Campbell County, 10 in LaFollette and 3 in Jellico. It would appear that in a fairly small

county--in population--such as Campbell County 13 lawyers could adequately serve the people, even those in out-of-the-way White Oak. Several reasons why this is not the case seem apparent: (1) problems are not readily identified by local people as being "legal" ones; (2) there is a lack of (a) money with which to pay lawyers should their problems be properly identified as ones which a lawyer could handle, and (b) transportation--the party line telephone system is not conducive to the confidentiality necessary to good lawyer-client relationships; (3) local people may lack confidence in the lawyers whom they know about and they are not inclined to "deal with" those whom they do not know by background, family, or other long-term relationship.

4. Medical

I assume this aspect of Campbell County has been commented on at length elsewhere. However, it should be noted that medical-legal problems are, in a very real way, bound together in relation to mountain life.

On October 14, White Oak officially opened the doors to its Health Center. This is a clinic staffed by one nurse, a lab technician, and a medical secretary. Two doctors are presently giving their services one day a month at the clinic.

Briceville

A. Background and Setting

Briceville was a coal-mining boom town up until the early 1900's. Once the coal mines shut down, the town shut down. Right now the "Briceville area" is probably 800-1000 people.

We came to Briceville mainly on the bidding of Tom Finley, the "health educator" with the Anderson County Health Department, who heard about our project and got the Briceville school PTA to invite us in.

As for the town itself, there are really three distinct parts to the town. The upper end of lower middle class people, the lower end of poor people, and the "airport" sector which are middle class Americans down to their flower gardens. None of the sectors will have anything to do with one another which makes for bad community action. The big rift was caused by an attempted incorporation of the town, voted down by 11 votes mainly because the lower classes didn't want to pay taxes.

Briceville is set just behind Walden Ridge of the Little Cumberland Mountains. This ridge is what divides South Anderson County which contains Oak Ridge, Clinton and Lake City (the prosperous areas) from North Anderson County which contains the mountain poor. Briceville is the first town back in the mountains and maintains close family ties with Lake City which is the first town on the other side of the mountains.

The political aura of the town was one of reliance on certain "community leaders" to get things done. There were a group of about six men who were the recognized spokesmen for the whole community.

The economic and environmental development of the area was stiffled by the fact that the Anderson County Planning Commission was completely dominated by representatives from Lake City, Clinton and Oak Ridge who refused to do anything in the way of economic development or zoning in the mountain area of Briceville, mainly because they feared that if they tried to collect fees or enforce zoning laws they would run into all kinds of "unimaginary horribles."

The homes in the area reflected the economic spectrum of the area. Everything from shacks to modern homes depending on how much money earned. Most houses had indoor plumbing. The chance for development is greatly increasing as the Interstate comes through Lake City. Lake City should boom as a suburb of Knoxville--Briceville may share in the boom.

These people were as religious as any I encountered this summer. It was the mainstay of their lives and it showed in their life-style. They were very cheerful, fairly intelligent people who almost always got religion into the conversation.

Their concept of justice was easy. You could buy your way out of almost any crime in Anderson County.

B. Available Services

There were no municipal services as such save a water line which was fairly decent though the bulk of the water was delivered by plastic tubing and, of course, electricity. Police and fire portection were non-existent; garbage disposal was by burning. Police protection in the county was by a sheriff's patrol and Tennessee State Troopers. Each of the three cities had their own police departments.

Clinton, Tennessee, the county seat, has a full range of state offices in a brand new court house. Though Oak Ridge, some 20 miles away, probably does have a good number of state offices along with a full compliment of federal offices. The basic and most needed agencies--Welfare, Social Security and Food Stamps--do come to Lake City on a regular schedule, or else it is a short trip (15 miles) to Clinton for welfare and food stamps and for the bi-weekly visits of the Social Security man. A permanent Social Security office is in LaFollette some 20 miles away. There is a Department of Employment Security in Oak Ridge.

Legal service is available in Lake City (5 miles) where there are four lawyers and in Clinton where there are as many as a dozen.

Medical services are furnished by two doctors in Lake City who run a hospital there. They are quite busy and many people go to doctors in Clinton and Oak Ridge where there are a good number of doctors (though not many who accept Medicaid patients). There is a hospital at LaFollette and also one in Oak Ridge, though they are not readily assessible without doctor referral. Without a referral, most end up waiting in the emergency room for a couple of hours waiting to be seen.

Institutional resources include TVA's regional office at Norris. OEO maintains a community action office in Clinton which has youth corps, manpower and job corps programs, though not on a major scale. The OEO also has opened neighborhood centers (5) in the mountain areas; the one at

Briceville was closed until we arrived. It seems that the center is a center of controversy with three different groups trying to open their own centers under different auspices, with none being successful due to lack of funds. A movement was on when we left to get the OEO operated one open again.

C. Method of Operation

The way I met people was usually through Byrd Duncan, one of the community leaders, and through the follow-up people who located the people to talk to and then I talked to them. In this way I got to meet and talk to just about all the community leaders and found out what problems were bothering them.

For the most part I acted as a resource man for the follow-up people--doing a lot of work contacting county officials, doctors, bureaucrats and any one of a number of people who needed to be contacted with regards to the scheduled health fair. In this way I made many useful contacts which would be helpful later on in dealing with the legal problems I was to encounter.

For example, meeting people and talking to them in their jobs meant I had someone to talk to and who recognized me when I came in with a referral for welfare, food stamps or Social Security. I talked to the county judge very early when I arrived and later had numerous conversations with him concerning a proposed creek straightening and dredging project in Briceville, and also about getting county funds for indigents (which were on occasion secured!) Legal problems centered around strip mining desecration--I spent days walking the mountains and taking pictures of orphan mines. Most problems centered around referrals to various agencies. There was an encounter with a UMW member who did not receive his pension. "Black Lung" questions were quite prevalent though the problem that stuck out most in people's minds was the promise by TVA to straighten out Coal Creek (which runs through Briceville) and to deepen it. It seems that the creek floods, badly destroying property. TVA has promised to pay for it if the county will do the work. The county claims that it is waiting for TVA to come across with the money. So far TVA has not and so the status quo.

Legal problems were not that prevalent here--most of the people were quite cosmopolitan--being so close to fairly large cities.

D. Evaluation

Reception was good--people for the most part were anxious to talk once they got to know you and once they saw you at church on Sunday and knew you were a good christian. Effectiveness was hindered due to lack of time to pursue any one problem, e.g. creek straightening, strip mining, Medicaid, to fruition. I, myself, was too involved preparing for the health fair.

Accomplishments

1. Gave people a better understanding of young Americans today and their concern for the poor and their dislike for the inequalities of the system.

2. Incorporation of a health council.

3. Got community action to sit up and take notice of a growing identity of the Briceville people.

4. Revived interest in incorporation.

5. Got dentists to look at people's teeth during the health fair.

6. Made people believe they could achieve something on their own.

APPENDIX A

Law Students Orientation Speakers

1. Harry Huge, attorney with Arnold and Porter, Washington, D.C. Mr. Huge has served on many public interest surveys and commissions including the Citizens Commission on Hunger and Malnutrition and is one of the attorneys for dissident miners in a suit against the UMWA Welfare and Pension Fund. Mr. Huge discussed different aspects of the Coal Mine Health and Safety Act of 1969 and school lunch programs and offered his ideas on the nature and scope of joint medical-legal programs.

2. Karl Warden, Professor of Law at Vanderbilt School of Law. Professor Warden was an attorney and district attorny in West Virginia and he described the operation and machinations of small town Appalachia politics and justice.

3. Jay Loeb, VISTA, attorney working with a Nashville-OEO community health center. Mr. Loeb explained the services available through and the rights of low income people to state and federal medical aid programs and the functions of institutional programs such as comprehensive health planning and the Hill-Burton Act.

4. Nelson Biddle, planner for the Tennessee State Planning Division. Mr. Biddle explained the operation of the state welfare and food stamp programs.

5. Norman Moore, former welfare official in Memphis, and Grayfred Gray, attorney with the Nashville OEO legal service program. Mr. Moore and Mr. Gray covered the complete process of application for welfare and the rights of applicants and recipients vis-á-vis the Welfare Department

6. Howard Thorkelson, former Director of Mountain Legal Rights Association (now Appalachian Research and Defense Fund, Inc.), Prestonsburg, Kentucky. Mr. Thorkelson covered specific problems raised by the Social Security standards for disability, the new "black lung" law, strip mining, medical cards, and the misuse of school lunch funds. Mr. Thorkelson provided valuable advice on the development, nature and scope of our project. He also organized a one-day meeting in Prestonsburg, which the law students attended, to discuss regional problems of health rights and possibilities and difficulties generated by expanding federal involvement in health affairs.

APPENDIX B

1. Have you ever received or been denied money by any of these programs?

	Received	Refused
a) old age assistance		
b) aid to the disabled		
c) aid to families with dependent children		
d) social security		
e) food stamps		
f) medicaid		
g) medicare		

2. If you learned you were eligible for any of these programs, would you apply?

3. Have you ever had a problem for which you wanted a lawyer?

4. Have you ever gone to a lawyer about that problem or any other problem?

a) if not, was it because	Yes	No
1) I don't know a lawyer		
2) they cost too much		
3) the lawyer lived too far away		
4) I don't think a lwayer would help		

APPENDIX C

Suggested Questions for Lawyers

1. Do you presently handle cases without fees?

   a) If so, how much and how often (i.e. what is your practice on this)?

   b) If not, why not?

2. Would you be willing to volunteer your time on a regular (weekly or monthly) basis to act in a legal advisory capacity in some (one) of the hearby communities in your county (Campbell, Claiborne)?

   a) If so, how often? Weekly ___ Monthly ___ Other ___

   b) If not, what are the major obstacles which would prevent your giving your services in such a way?

   _____

   _____

   _____

3. If it is generally found that local lawyers are unable to assist in rendering free legal services to people in remote areas of your county, what means would you propose for seeing that such people do have access to legal advice and counsel?

   _____

   _____

   _____

   _____

4. What do you consider to be the major legal problems which beset the people of outlying parts of your county (Campbell, Claiborne)?

   _____

   _____

   _____

5. Would you be willing to	Yes	No
a) talk with a community group about their (legal, health) rights		
b) meet with local community delegations in your office about specific problems which they as a community want to confront		
c) hire a law student during the summer to work with people in remote areas of your county		
d) have a self-supporting law student work out of your office with people in remote areas in your county and have the benefit of your counsel and advice pertaining to the problems which he or she encounters, but not obligating you to handle potential cases which may be found?		

Personal Evaluation

Arnie Rosenfield

I guess that you might compare my thoughts about this summer's project with the weather. Both changed from day to day and even during the course of single days. The amount of vascillation corresponded to the amount of time I took each day to reflect on what the project was doing.

On the days when I was busily scurrying about the countryside seeing county officials and running errands for the follow-up people, I thought little about the problems which were present. Even though I was doing very little legally-oriented work, I was gaining valuable experience meeting and talking to bureaucrats, officials, etc., and their constituents. As there was no planned project for the law students, I ended up an adjunct to the follow-up people. This proved to be beneficial to all involved, since they always had a lot to do and I got to keep busy. But, I believe their time and mine could have been better spent.

The format for the rest of this essay will be to list suggestions that might have improved the project if they had been implemented. Under each suggestion, there will be an analysis of the summer's work and my experiences in the area covered by the suggestion.

I. Concentration on fewer geographical areas.

Of course, hindsight will always be easier than foresight, but it is surprising that no one felt that eight areas in eight weeks would be a little too strenuous. If four areas had been chosen and two weeks spent at each place it would have made for a much happier and valuable experience for everyone involved.

We spread ourselves too thin. There were too many people to see in too few days with too much follow-up work for just two people. This could have been eliminated. If we had only gone to four places there would not have had to be such long hours--more time and a more leisurely pace would have meant a better job done on those coming through the unit. This also would have meant less exhaustion and less dissatisfaction with working conditions, etc. With four follow-up people in a community, their task would have been made easier. With more leisure time the people on the unit could have gotten into the community to meet people on a social level.

Organizationally, with only four areas to worry about, one medical student could have been put in charge of one area and

been responsible for making all the arrangements. He could have commuted to the area or even lived in the community for the two weeks prior to the fair and then worked while the fair was in his area.

Concentration on four areas would have simplified communications. With only four different areas to notify, it makes things a lot easier, especially if there is one person who is a lieutenant in the area. This arrangement would have precluded the weekend extravaganzas.

II. Comprehensive follow-up program headed by a medical student located in the area.

Follow-up was hampered in my area by an over-abundance of paperwork and a lack of real knowledge about the program by the doctors in the area. Somehow, I don't think that the doctors in the area were impressed by a law student representing medical students. It would have been more effective if a medical student had visited all the doctors in the area. In doing so, the medical student could have asked for their help in getting aid for the sick emergency cases. If each of a half dozen doctors agreed to handle three or four indigent cases, all emergencies could have been taken care of. This prior arrangement would eliminate the stopgap measures which were employed this summer. It also would have given the student some insight into medical care problems in the area. Most notably, the problem of doctors saying that "they do accept new Medicaid patients," when in reality new Medicaid patients are quietly shown to the exist.

Having a team of six (4 follow-up, 1 medical student and 1 law student) in each area, with one medical student in charge would have given all involved to do some in-depth work on problems confronting the people.

Some of the problems in my area which were worth investigating were:

a) The effect of the church's leadership on the community. I suspect that it is a detrimental one.

During the course of the summer we met many people who were intellectually depressed as well as being semi-literate. Much of this acquiescent, depressed state can be linked to a church leadership (i.e. preachers) who tell people not to question their existence but merely wait for the next world. A leadership which each Sunday calls on men to give money they do not have so that the preacher can induce him to cry and wail out loud. I submit that not all answers to the people's problems are to be found in the Bible as our evangelical brother would like these people to believe. Though I believe many are caused by the evangelical spirit.

The church and lack of adequate schools are as responsible for the plight of the people as is the lack of jobs. Physical and economic supression is not as harmful as mental and intellectual suppression. Once the latter has been overcome, the individual can become capable of tackling the former with more resolve and determination.

b) Teacher qualifications and general quality of education. There are some teachers in these areas that do not even have a bachelor's degree. Books and equipment are 5-10 years behind the times. School boards are political playthings.

Time could have been spent trying to formulate a program for bettering education. Give the kids some reason to go to school.

c) Price fluctuations on day's food stamps are distributed. Local markets in these areas charge exorbitant prices on all days but certain prices seem to rise around food stamp day.

d) Strip mining and related problems.

e) Following through on promises made by local officials to communities and not yet carried out. This would involve organizing communities into action groups.

A study on any one of these topics could have proven invaluable for the purpose of obtaining legislative or foundation commitment to future action.

III. Organizing within the community and between communities.

Probably the biggest problem faced this summer was getting people to talk to each other in the Briceville area. With more people from our group living in and encouraging communications in an area, who knows what a united group of people could do--or what pressure they could exert?

IV. Develop some kind of idea of what legal aid you will need on the project.

Law students can be good for something, if there's something they can work at being good at!

Personal Evaluation

Rob Leonard

General Comment

It is my design to assess briefly, yet candidly, this summer's project conducted in eight rural communities of Tennessee. I profess no competence to evaluate all aspects of the project and, thus, will confine my remarks to those areas with which I am most familiar. I will refrain from boring the reader with a commentary pregnant with praise, although much of what was accomplished this summer is laudable. It is my intent, therefore, to critically evaluate the summer's work as objectively as possible.

I find it incompetent and difficult to assess the overall success of the project because follow-up, whose importance is tantamount to health-need definition and diagnosis, remains in progress. We have been well schooled and instructed not to "raise the expectations" of the people we diagnosed, a circumstance which can only be avoided by effective follow-up. Therefore, pending the results of our follow-up in the eight communities, pending the results of our follow-up in the eight communities, I must reserve general assessment of the summer project and will discuss those areas that invite specific comment. I will suggest and recommend where appropriate.

Mobile Unit

A. Operational

Generally, the daily operation of the Mobile Unit proceeded well. Bottlenecks and other mechanical problems occurred, as they will, especially in the early stages of the week but were effectively remedied in most instances. Some health fairs proceeded more smoothly than others, a circumstance attributable to the quality of volunteers. We have little control, beyond the routing system, over the operational success of the Mobile Unit because of our necessary dependency on the volunteers. I feel that the cooperation we received from local superintendents of schools varied with each community but was generally adequate.

It is my feeling that more sensitive consideration was deserving our <u>own</u> personnel regarding the length of working hours hours and free time. I observed that our personnel were most willing to do as much and more as was asked of them. Much personnel sacrifice, measured in mental and physical fatigue, was

expended for the success of the project. Many individuals who signed on and expected to perform specific tasks wound up in jobs with which they were totally unfamiliar and untrained. But they learned and adapted quickly because it was required. However, there is a physical and an emotional threshhold beyond which an individual ceases to function effectively. The natural result of long hours, large numbers and disorientation to task and environment is a psychological pressure and strain whose intensity is unique to each individual. Therefore, I emphasize the importance of one's own free time and believe it should be granted liberally.

As the summer progressed, the call of meetings, so essential during the first few weeks of initial adjustment, continued with constant regularity and, thus, proved to be a continuing source of annoyance. The meetings struck me as being unfruitful beyond the infrequent "news" related at the same and inapposite to the group assembled as a whole. Smaller, more informal meetings, comprised of people whose presence was <u>essential</u>, would have been more effective and productive.

My most severe criticism regarding the Mobile Unit's operation is with the apparent insensitivity and/or lack of planning with which the working hours were scheduled. To my surprise, I discovered that we had little or, in most instances, no voice in the arrangement of hours. It is a sad commentary and perhaps the biggest oversight of the project's organizers that we did not have vocal representation when the hours of the health fairs were arranged. Morale seemed at its lowest when the hours of "next week's health fair" were announced especially after another "record breaking" week. My obvious recommendation, whose importance cannot be overly stressed, is that we insist on such representation in any future project and that the organizers remain aware of the sensitivities of their personnel.

B. <u>Functional</u>

The medical work on the Mobile Unit was essentially diagnostic and, thus, provided an excellent teaching laboratory for the medical students and nurses. I am certain that the experience they received this summer will greatly benefit their respective professional careers. Here, I must defer specific, medical evaluation of the Mobile Unit's success to the medical personnel.

The Mobile Unit itself and its weekly health fair functioned as the focal point of the project. The health fairs

were the keys of entrance for our personnel into the local communities to publicize and arrange the Mobile Unit's arrival and, upon its departure, to remain and follow-up. However, I question whether the central thrust of the project should be directed toward the Mobile Unit's activity.

It is my suggestion that any future project emphasize community activity and involvement beyond the level apparent this summer. Of course, within a summer's time it is difficult to gain acceptance into a community, recognize its problem areas and effectively remedy its infirmities. However, if the number of fairs were reduced by half, if locations were discriminately selected and if the length of the fairs was increased from a week to ten days, such a shift in emphasis from the Unit to the community could be accomplished. The location of more people in the community, more extensive preparation and more relaxed follow-up and, perhaps more local involvement would be consequent. The Mobile Unit still would function of necessity as the diagnostic center and teaching lab. But its role as the hub around which all else in the project revolves would diminish or extinguish in favor of the community.

C. Law Students' Role

Two law students located with the Mobile Unit during most health fairs. I was one of those two during 5 of the 8 weeks. Nominally, our role was legally-oriented. In fact, our function was ill-defined and uncertain.

During orientation, we familiarized ourselves, as much as possible, with welfare rights, Social Security law, Medicare and Medicaid, the food stamp program and black lung legislation. We were basically prepared to function as a source of information regarding these programs when the health fairs commenced. It became quickly apparent that our work would rely heavily on the medical students' cooperation. Few, if any, patients were attracted to our table on their own initiative. The vast majority of the people with whom we spoke were referrals from the medical students. Their cooperation was essential and thankfully forthcoming.

In retrospect, I feel that the Mobile Unit was overstaffed, i.e. two law students were available where only one was required. Murfreesboro, where we experienced our heaviest workload, alarmed us to believe we would continually need two law students on the Unit. Such an assessment on our part was ill-conceived. As our confidence grew with each week, it became apparent that we were wasting manpower, a situation we did not rectify until the last few weeks.

It is my suggestion that only one law student be assigned to the Mobile Unit in any future project and then, not necessarily in a permanent capacity. Nothing is more frustrating than to observe medical students and nurses rushing about while the extent of your labor is to turn the next page in your novel or to wage war against the ubiquitous fly. The feeling of uselessness became quite acute. Therefore, the law student should be granted flexibility to come and go when and where needed. He should be available to assist in preparations for other health fairs and aid in follow-up once it commences. If other law students locate in the four communities, they could devise a schedule to adequately service the Unit during the health fair in their community.

I also suggest that a legal survey, designed to quantify the legal needs and problems in the communities, be included in any future project. If the need is demonstrated statistically through such a vehicle, the possibility of attracting legal services of a permanent nature would become more real and concrete. The questionnaire can be worded sensitively and economically so as not to confuse, alarm or anger those to whom it is asked. A survey should not be administered if its only purpose is to accumulate data. But if its design is to demonstrate the legal needs of a community to sources amenable to funding a legal services project, its value can not be overestimated or overly emphasized.

Personal

I have benefitted greatly from my participation in this summer's project. The interaction with these mountain people whose culture, mores and values are so diverse from my own was of inestimable value. I have realized an acceptability and tolerability within myself with which I was previously unaware. I experienced myriad emotions this summer--loved, hated, feared, trusted and mistrusted more passionately and more fervently than ever before. The intensity of involvement, or desire to involve myself, in interplay with others magnified as the summer progressed. The payment, in terms of personal sacrifice, was slight when measured against the educational return. I have gained much upon which to reflect and with which to take with me. Perhaps the greatest pleasure of the summer was to work with people as dedicated and sincere as those involved in this project. This too I shall remember and value.

Personal Evaluation

Robert Alan White

Personal Reactions to the Summer

I came to Nashville on June 1st hoping to learn about a section of America which was alien to me. As the summer draws to a close, I feel that my hopes have been fulfilled. This is not to suggest that there could not and should not be changes in next year's project. I believe strongly that numerous changes are needed and I have outlined several below. But on balance, I have been satisfied with my summer for two reasons. First, I believe that I have a much better understanding of the problems confronting the rural South, particularly in the mountains, and also of the enormous difficulties many people encounter trying to secure medical care. Secondly, the experience of talking, working, and living with local residents was very rewarding in helping me respect and appreciate a culture very different from my own.

Project Critique and Recommendations

The Role of Law Students

The role of the law students working with the project was from the outset ill-defined. After several weeks of working with the mobile unit I have concluded that one law student would be sufficient for any future project. In several stops there was very little, if any, "legal" work to do. Nothing is more frustrating than to see everyone else on the unit working hard and have only one or two people brought in to see the law student during the entire day. The one law student could alternate between the follow-up communities and the unit. In his absence most questions could be answered by reference to the resource handbook prepared by the law students this summer. Every follow-up worker should have a copy of it. This would limit the need for his presence in any particular spot.

Because of the nature of the project, unless the law student could become associated with a full-time attorney or legal services project in the area, the law student should be made aware in advance that there is really very little legal work to be done. Unlike the medical students and nurses, he does not really function within his professional competence, but rather serves as a medical social worker. While much can be learned from this work, little will be related to developing his professional skills. I do not feel that this would deter someone from taking the job; it would, however, give him a more realistic appraisal of what to expect.

The absence of a legal services project or attorney to work with also severely restricts the scope of the problems which can be attacked. Many problems which could and should have been tackled required the prestige and authority of a practicing attorney. Because of the desperate need of so many people living in the areas we visited for legal assistance, I feel a full legal survey documenting this need would prove extremely valuable in raising funds and personnel for such a project. We were told when the project began that a questionnaire intended to elicit the relevant information would offend the mountain people, that they would refuse to cooperate. After seven weeks with the mobile unit, I believe this is mistaken. A questionnaire properly worded and asked by one of our people (not local residents who know each other) would, I feel, be accepted much as the medical survey in the valley was accepted. Next year this should be included as part of the program, even though the legal staff should be cut.

Mobile Unit

The mobile health unit is the key to the success or failure of the entire project. Thus any problem arising on the unit has an importance exceeding that which is immediately apparent. For this reason I believe that several changes should be instituted to improve the overall effectiveness of the project.

Locations - More thought and planning needs to go into the selection of the towns where we are going to set up. The stop in Smithville was unjustified by the turn out we had. One week or eight days would have been more than adequate to handle this area. Similarly, the one week devoted to both Murfreesboro and Briceville was inadequate. Each of these stops warranted eight days to two weeks. There is nothing sacrosanct about the one week stay, more flexibility should be built in during the planning.

Personnel - Several times during the summer problems arose on the mobile unit because of the general inconsideration of the personal needs of the people working on the unit. Repeatedly the complaint was made that too many patients were being seen, there were too many meetings, and that no one had any time to himself. Because no overall policy was initiated at the beginning of the summer regarding the daily quantity of patients to be seen, several times the people on the unit were pushed beyond the point where they could function properly. The question of quality versus quantity arose wherever large numbers of people were served. No one wants to refuse anyone the facilities the mobile unit has brought to their community, but if we are to live up to the promise we hold out--first rate medical care--then we must limit the number of people we see each day and rigidly adhere to our limitation. Several places within the limit should be held open for extreme hardship patients.

Another factor which should be altered is the assignment of jobs. Certain jobs are simply less pleasurable than others and everyone should have to handle the unpleasant jobs within his competence on a regular rotation basis. Thus all medical students would rotate doing women, men, and children; the nurses likewise rotating smong the various jobs.

The project should be careful not to take on more communities than it can adequatelyhandle and complete follow-up on. During the middle of the summer there should be a week break, during which charts and follow-up could be brought up to date, the personnel of the unit could get a much needed rest, and everyone could get together to reevaluate the summer to date.

Meeting the folks

For many members of the unit one of the disappointments of this summer has been their inability to meet with the local people and get to know them. The brief talk preceding the drawing of blood hardly constitutes an exchange of ideas. Even those living with local families have little time to be with them and get to know them. This situation would be improved if the time not scheduled for health work were left free. That means fewer meetings and when meetings are scheduled they be arranged at times more suitable for everyone.

Follow-Up

Comprehensive follow-up is an important element in the overall plan to uplift the health standards in each community. The local health council should become as involved in this phase as is feasible in each area. The council would thereby expand its recognition as a viable organization within the community and hopefully increase its local base of support.

I think it unnecessary to place two people into each community for the entire summer. While it can prove to be a valuable experience for them, it has marginal value to the project. A team of three people sent in two weeks prior to the fair could arrange all the final details. These three people with perhaps three others could return for a week or two after the charts are done and do a rapid but comprehensive follow-up job. The idea of injecting a team of several follow-up people into an area is similar to what is planned for the last two weeks of this summer. If each of these people had a car at his disposal, the follow-up task could be handled quickly and effectively.

This report is necessarily brief and excludes many comments about all the things I felt have gone fine all summer. The important thing is to improve next year, however. The orientation program was comprehensive and well planned, and the local groups in most communities did a great job. I have learned a lot and enjoyed my summer. The most satisfaction, however, has come from working with a team of really great kids. We had a good group of people and I was happy and proud to work with them.

Comments on Mobile Unit Operation

Bob White

As law students working on the mobile unit, we encountered a wide variety of human and legal problems. Because those of us associated with the project are still students and not members of the bar, we had to limit our activities to advising and referring. On the mobile unit this activity was primarily oriented toward the availability of health services. We had frequent contact with the various agencies to which we referred people (e.g. Welfare Department, Public Health, Social Security). Prior to our first week on the road, we had been led to believe that most of these governmental agencies would be hostile to our efforts and that they were working against the best interests of the people in their county. During the summer we had occasion to meet and work with representatives of numerous agencies in several counties. Based upon our personal experience throughout the summer, we have found just about everyone cooperative and anxious to help us in our efforts to help citizens of their county. After our initial visits (a visit to all agencies on the first day of each fair was our regular practice) several directors and workers visited the fair later in the week. They were always open to referrals made by us. We were quite impressed by their attitude.

There were many people with a desperate need for public assistance and/or medical care and much to our despair we could only advise them that no help was available. One category of people repeatedly turned up--widows between 50 and 60. Usually their children have grown and married so they could not get AFDC. They are too young for OAA--Old Age Assistance (age 65 for eligibility), or for survivors insurance under Social Security (age 60 for eligibility). They are in an age group which makes employment acutely difficult, particularly in the areas we visited where jobs are at a premium, even among the young. They usually have physical difficulties, but not bad enough to qualify for assistance as "permanently and totally disabled."

Another problem is with teeth. No assistance program exists to pay for dental care. Even those on Medicaid cannot have dental care paid for. This is particularly a problem with children. We saw many children who had lost over half their teeth by age five, and some who had lost all their teeth by that age. This, of course, forces the permanent teeth in prematurely and creates dental problems for the full life of the person. The only coverage available is a small fund of Head Start money which is used

to treat the teeth of some of the children selected for that program. But this covers only an extremely small percentage of children. An educational program on television aimed at parents and children as well as one within the school system would be a small step in the direction of abatement of the problem. A statewide flouride treatment program in the schools would also contribute to the preservation of the permanent teeth.

The law students function on the mobile unit was vague as the summer project began. As his role became defined with each week on the road, several things became obvious. First, in most communities the unit visited, the law students had nothing to do a large portion of the time. Secondly, many of the referrals brought to him were unnecessary. If the medical student who examined the patient had asked one or two relevant questions, he could have discovered that a referral would be fruitless. This observation is made not as a complaint against frequent referrals, (when one has nothing to do all day, one welcomes the opportunity to talk with almost anyone), but rather as a background for the suggestion that a law student operating full-time with the unit is unnecessary.

There are several options available for next year's program.

1. The organizers may decide that a law student's presence is required full-time with the unit and that the long periods of inactivity are just a consequence of the nature of the project and thus to be accepted. I believe this option is undesirable from the standpoint of both the law student and the project.

2. Another option would be to train the law student to perform other duties on the unit and give legal advice as the need for it arose. This, too, I feel is unsatisfactory. Few jobs which the law student would be doing would permit frequent interruptions and perhaps long absences from work.

3. The third option is to have the law student work part-time with the unit. The pre-health fair publicity would announce one or two days and the times during the fair when the law student would be present. If legal problems arose on other days, they could be noted and he could visit the people seeking advice during his visit to the fair. Any others would be searched out by him during follow-up. Necessary to the success of this program is a comprehensive orientation in the basics of the various assistance programs so that those who can be easily eliminated

from active follow-up are eliminated. The public assistance handbook written by this year's law students could serve as the basic text and reference book for the brief orientation which should be given in early June.

When not actively working with the unit, the law student should be working on follow-up (legal and general) in the communities already seen.

Personal Evaluation

Lark Hayes

I spent about one half the summer with the mobile unit testing children under 6 years and the later half of the summer living in a community doing mental health follow-up and assisting in general medical follow-up. The scope and diversity of my work was atypical and, I think, provided me the opportunity to observe the project from many different perspectives. Because I participated with follow-up as well as working on the unit I became very aware of the attitudinal differences and tensions which, I feel, definitely existed between the two groups. These diferences were a result of several factors including (1) differences in persons recruited as undergraduates and medical students, and (2) differences in experience and community exposure which led to further divergent views. These differences of opinion and attitudes were often subtle or vague but detracted from the unity of the project. They could be dealt with by (1) spending time during orientation exploring the expectations of all members of the project, and (2) by providing a more common base of experience for all those in the project, i.e. everyone should have some experience with the unit and with follow-up. Simply living in homes for a week (unit people) or spending a week with the unit (follow-up people) is not enough exposure. Perhaps one good way to involve the mobile unit staff more deeply with the "folks" is the identification of each staff member with a particular community. Other staff members should be allowed time off the unit to spend in that community performing general follow-up duties and providing medical expertise when possible. Although this plan would probably mean less medical manpower hours on the unit, it seems absolutely necessary for exposing the staff to meaningful interaction with the people we are striving to work for and with and for avoiding tension and conflict between the unit staff and the follow-up people. Currently it is inconceivable to me that medical personnel can develop an in-depth understanding of the people and their humam problems if they are doing physicals or immunizations 18 hr. per day. Perhaps post Health Fair Clinics such as April and Darrell's blood pressure and diabetes clinic could provide opportunities for more community participation by the medical staff while also utilizing valuable medical expertise.

In evaluating my work in the area of mental health, I feel it necessary to make a clarification that was not fully appreciated by some this summer. This classification concerns the distinction between purely medical pathology and mental health problems. Medical problems can often be diagnosed and treated with the appropriate medicine and a cure can be expected within an X amount of time. Mental health problems are by their nature more complex, more likely to be complicated by other factors. This is particularly true when dealing with children because they

are victims of all family problems (for example alcoholism/unemployment of the father) as well as the cultural mores of child rearing peculiar to East Tennessee. Much of my summer was spent in trying to discern and understand the child rearing pattern and develop a concept of a healthy child more or less with the cultural framework. These kinds of concerns are obviously more difficult to deal with than some medical problems.

Two additional problems in the project's mental health aspect were (1) the length of time involved, and (2) the personnel and training involved. Because this was a new aspect of the summer program, there were several blind alleys encountered--time used discovering what was feasible and what was not, for example Smithville. Given the problems worked out this summer and the knowledge of the area and people gained this summer, I feel that a mental health worker will be able to be increasingly productive in future programs. Concerning the personnel and their training, it seems very important to do more recruiting at school such as Peabody where the curriculum is directed toward more practical problem solving and application of education. For all personnel, regardless of their backgrounds, much could be learned about how to set up programs and do testing if preparation for the summer was started much earlier. There are many persons within the University area who would be willing to contribute ideas and give training to mental health workers if time were available.

Even these preparations, however, would not solve a fundamental problem of the mental health area, that is, that we are essentially screeners of problems and not treaters of problems. The time is inadequate, as well as our training and resources. This nessitates more concentration on development of programs which are independent of ourselves but which we can utilize on a referral basis. We can help here in showing the crucial needs of the area to those who are able to effect chang. This need for cooperation seems particularly reasonable in Anderson County (Briceville) where I lived this summer.

The final comment I would like to make concerns the quality of medical care which characterized the project. This was of much concern to many people on our staff, medical and non-medical alike. In many cases improving the quality means reducing the number of physicals done per hour. This probably means staying in some communities two weeks. This does not seem to be a poor idea because the satellite clinic system could be used to give more comprehensive care to the area and, secondly, it would give the unit staff more time in a single place to learn about and

appreciate the intricacies and complexities of a community. A second way to improve the quality is creating a more teaching-and-learning atmosphere, one in which continual self-criticism and evaluation is common. This type of atmosphere Dr. Pete Moss tried to create this past summer. This definitely needs to be encouraged, perhaps, by some sort of formal structure. This does not seem to be something the medical student or nurses would object to because many view this project as a potentially important learning experience.

8/21/70

Dr. Christie,

The Vanderbilt-Meharry Coalition was a success and a failure at the same time. As an educational experience and as a chance to work with Meharry students it was a success. I am not so sure, however, that it was successful as an innovative service to the community. I am not so sure that we provided any service that was not provided for already by the system, and this really bothers me.

Our project could be considered a success in several ways. It was a program conceived, initiated and worked out by medical students from two different medical schools, two different races, and two different ways of thought--and yet it worked. We made many of the people we saw feel that we were really interested and really cared about them and their problems. Above all else, however, we were exposed to a group of adults and a group of children that otherwise may have been completely left out of our lives. We were also exposed to the system and beauracracy that attempts to deal with these groups. I feel that one of the big, big problems is that people do not know how to use the services available to them. Agencies are good in theory but in practice they are too big and too far from the people.

I consider the summer primarily a social experience and secondarily a medical experience, though the two are hard to separate. I will not forget the physical signs of rickets, but even more vivid in my mind is a beautiful little blond-headed girl terrified of men as a result of having been sexually molested. Pronogis?--very poor. Those are the type you worry about and do not forget, ever.

The problems I have seen anger, disgust, frustrate and challenge me all at the same time. After this year's experience I am sure that we could develop a program for next year that would be more effective and reach more people--the latter being one of my main concerns about this year's project. At least one person is needed to do full-time follow-up work. The chance to choose and develop your own project was one of the most appealing points of the job this year as far as I was concerned.

The summer's experience has taught me that the doctor and medical student cannot remain aloof from the political, social, environmental, and economic problems around them. Doctors and medical students must be activists or they are falling short of their "duty." This may seem idealistic, but that is how it is as I see it.

Bill Watson

Dr. Christie,

I used the following criteria in selecting a job for this summer: 1) adequate pay, 2) clinical experience, 3) service opportunities, 4) time to relax and enjoy the summer. The Vanderbilt-Meharry project met all these criteria and provided much more responsibility and freedom than I had expected to find in a summer job.

The experience gained in planning and organizing the project, though frustrating at times, was very worth while. I feel that a knowledge of the workings of the Welfare Department and community health programs is an important part of a medical education.

Working with the Meharry students presented no problems. I see no reason why Vanderbilt and Meharry students should not be able to work together in the future. However, I do not see where such a small start as our project can lead without much more communication on the administrative and faculty levels.

I thought our orientation to physical diagnosis was well planned and carried through. It might have been helpful to have some more supervised practice to supplement the lectures and to separate the nurses and medical students so that the medical students could go more deeply into most parts of the physical examination, especially in the area of interpretation of findings. I thought doing physicals on the camp children was very helpful, as was seeing patients at Vanderbilt University and the Veterans Administration.

The disability examinations were probably the most beneficial part of the project as far as my own education is concerned. Working with upper class students, reading hospital records, and reviewing the physiology involved in the various medical problems were all very beneficial. At the same time, this was undoubtedly the most frustrating part of the project because of my lack of experience and problems in follow-up, obtaining medical records, and poor attendance. All things considered, I would recommend discontinuing this part of the project. I felt that my lack of knowledge and experience prevented some applicants from getting an accurate and comprehensive evaluation and the stakes here are too high to have an inadequate evaluation.

I thoroughly enjoyed working with the foster home children. I felt that this job of giving screening physicals was within the limits of my ability and training. Here the problems of follow-up, records, and attendance are largely removed, making the whole operation much more efficient and satisfying. I think this part of the project should be continued in following summers if at all possible.

Dr. Christie, we certainly appreciate all the time you gave us. We realize how hard it was for you to supervise and be responsible for all three projects.

Ed Anderson

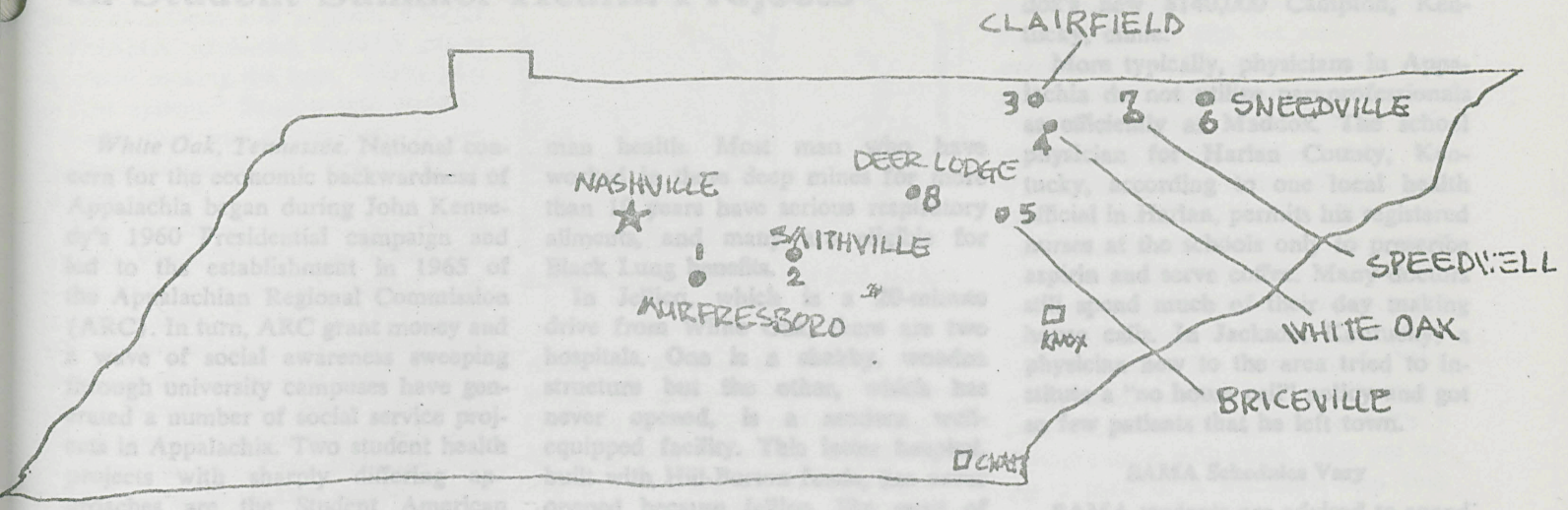
As one of the nine medical students involved in the Vanderbilt-Meharry summer health project of 1970, I can make several personal observations about the project. I feel the project as an educational experience was of great value. The opportunity to create, plan and organize a project within the existing framework of present health services was unique. Contact with the local health department and Welfare Department acquainted project participants with methods of health care delivery. Such contact is not a part of the present Medical School curriculum. Setting up one's own clinic was certainly a learning experience. Perhaps we attempted too much by moving our clinic each day. One gained an appreciation for a well equipped, well staffed examination facility. For a first year, patient oriented medical student, the project offered an introduction into what medicine is all about. Where the basic science curriculum of medical school tries one's interest in medicine, this project stimulates one's interest. Certainly, pathology and pharmacology will be fascinating because I will be able to correlate thse courses with a patient's problem whom I have seen. Finally and most importantly, working on an equal basis with well educated, motivated blacks and with similar professional goals was an experience that could not be had anywhere else in Nashville. Working with such a group is often frustrating and time-consuming. Because each person of the group was probably too conscious of the other, one of our biggest problems was establishing leadership of the group. No one person or persons were able to or attempted to direct traffic (i.e. implement ideas). Consequently, a great deal of duplication and lack of organization caused some jobs to be done two or three times while others were left undone. However, our group, I feel, was a successful model coalition of the ones which will be forced to solve the medical problems of our nation. Vanderbilt Medical School has not provided its students with an opportunity to work with blacks in the medical profession. Our group should have spent time in encouraging professors of both Vanderbilt and Meharry to participate in our project.

The summer project enabled the group to provide a service to the applicants for welfare disability aid and to the children under foster care. Working with the former proved to be a bad choice of projects. Difficulties in scheduling, problems with transportation of patients, the complicated nature of the patient's medical history and the necessity for follow-up were some of the problems which we met with little success. Work with the foster children was much more rewarding both to us and to the recipient. This project, with the inclusion of children in day care centers, should be continued by medical students. Our project as an educational experience could be strengthened by including the medical student in the follow-up work done by the specialist. I would have enjoyed seeing more children over a longer working time.

Financial remuneration by the Macy Foundation was a necessity for me. In the future, our financial difficulty with the Meharry accounting department should be eliminated.

Joe Holliday

SCHEDULE OF THE STUDENT HEALTH COALITION'S MOBILE OPERATIONS SUMMER 1970



JUNE 22 - 27 _____ MURFRESBORO (RUTHERFORD CO.)

JUNE 29 - JULY 4 _____ SMITHVILLE (DEKALB CO.)

JULY 6 - JULY 11 _____ CLAIRFIELD (CLAIBORNE CO.)

JULY 13 - JULY 18 _____ WHITE OAK (CLAIBORNE CO.)

JULY 20 - JULY 25 _____ BRICEVILLE (ANDERSON CO.)

JULY 27 - AUG 1 _____ SNEEDVILLE (HANCOCK CO.)

AUG 3 - 8 _____ HABERSHAM (CLAIBORNE CO.)

AUG 10 - 15 _____ DEER LODGE (MORGAN CO.)

NAME _____ DEPT. _____

LOCATION I WILL VISIT _____

DATE: FROM _____ TO _____

Appalachia: Two Approaches In Student Summer Health Projects

White Oak, Tennessee. National concern for the economic backwardness of Appalachia began during John Kennedy's 1960 Presidential campaign and led to the establishment in 1965 of the Appalachian Regional Commission (ARC). In turn, ARC grant money and a wave of social awareness sweeping through university campuses have generated a number of social service projects in Appalachia. Two student health projects with sharply differing approaches are the Student American Medical Association (SAMA) program, where medical students are assigned to local physician "preceptors" throughout the 13 Appalachian states, and the smaller, less Establishment-oriented Vanderbilt group, whose series of "health fairs" in different eastern Tennessee communities are providing free multiphasic screening.

The Coal Economy

For 10 days, this reporter traveled through eastern Kentucky and Tennessee—the core of Appalachia—primarily observing the SAMA and Vanderbilt programs. The Vanderbilt group spent 1 week in White Oak, Tennessee, an unincorporated township not found on most Tennessee maps and more or less typical of the communities which the project serves.

White Oak's economy was largely based on coal until recently when most mine operators preferred to close down rather than to meet the more stringent regulations of the new Coal Mine Safety Act. Most older miners remaining in White Oak are now unemployed and have gone on welfare. Younger men seeking jobs were forced to look for work at the factories in cities such as Cincinatti.

The coal industry's decline in White Oak, however, has its brighter side. Illegally overloaded coal trucks have gouged the winding treacherous roads, and strip mining operations have devastated whole hillsides and polluted wells with sulfuric acid. The deep mines have taken a serious toll in human health. Most men who have worked in these deep mines for more than 10 years have serious respiratory ailments, and many are eligible for Black Lung benefits.

In Jellico, which is a 20-minute drive from White Oak, there are two hospitals. One is a shabby, wooden structure but the other, which has never opened, is a modern well-equipped facility. This latter hospital, built with Hill-Burton funds, has never opened because Jellico, like most of Appalachia, has not been able to attract enough health professionals. The situation in White Oak and Jellico, if not typical, at least symbolizes the problems of inadequate health care in Appalachia.

The SAMA and Vanderbilt summer programs are both aimed at providing better health care to Appalachia. SAMA's long-range objective is to interest health science students, especially medical students, in coming to Appalachia to practice after their internships and residencies. The SAMA organization, strongest of the student groups in the health sciences, is running this year's program on a 1-year $274,000 ARC grant and on a small grant from the American Pharmaceutical Association which supports 14 pharmacy students. Now in SAMA's second year, there are 141 medical, nursing, pharmacy, and dental students through 12 of the 13 Appalachian states, and each student is assigned to a local preceptor who can introduce him to community officials and "legitimize" him in their eyes.

Experiences with the local physician preceptor vary greatly. Some physicians let their students, most of whom are to begin the second and third year at medical school, take histories, give physicals, and even deliver babies under supervision. Other physicians want their students just to look, not to touch.

Among the SAMA preceptors, Dr. Paul Maddox is unique. He has received national publicity for his Medicaid receipts, which were $106,112 in 1969. He employs paraprofessionals and does not make house calls, in contrast to most local physicians who spend many valuable hours each day on the slow mountain roads. Consequently, Maddox and one partner treat as many as 270 patients daily in Maddox's new $140,000 Campton, Kentucky, clinic.

More typically, physicians in Appalachia do not utilize paraprofessionals as efficiently as Maddox. The school physician for Harlan County, Kentucky, according to one local health official in Harlan, permits his registered nurses at the schools only to prescribe aspirin and serve coffee. Many doctors still spend much of their day making house calls. In Jackson, Kentucky, a physician new to the area tried to institute a "no house call" policy and got so few patients that he left town.

SAMA Schedules Vary

SAMA students are advised to spend 2 days a week with their local preceptors, 2 days a week talking to community officials, and 1 day a week working on special projects, such as that of Maddox's student, Robert Cooper, who spends many hours each week talking to Wolf County officials, trying to persuade them to set up a public ambulance service. Cooper is also overseeing negotiations between the two Campton funeral directors, who provide ambulance services but are losing money. He hopes that they will not phase out their ambulance businesses until a public ambulance service is set up. Because SAMA is structured so that each student will "do his own thing," this means that, at a given moment, a student may be riding an ambulance, talking to a local politician, working closely with his physician preceptor, or picnicking in the Appalachian hills.

Those in the SAMA program are given specific instructions not to antagonize the local medical establishment and, therefore, the student is supposed to observe, not to innovate. Dr. Joseph B. Deisher, the host physician coordinator, wrote to the local physician preceptors, "They [SAMA students] have been cautioned that their purpose is NOT to make changes (the time is much too short to even understand what might need changing, if anything)."

The 2 days a week that SAMA students spend talking with community officials gives them some idea of the scope of the problems in Appalachia. But the school, court, and public health

officials which SAMA students approach are often the same ones that the Vanderbilt group, which emphasizes grass-roots participation, holds in contempt for not really caring about poor people.

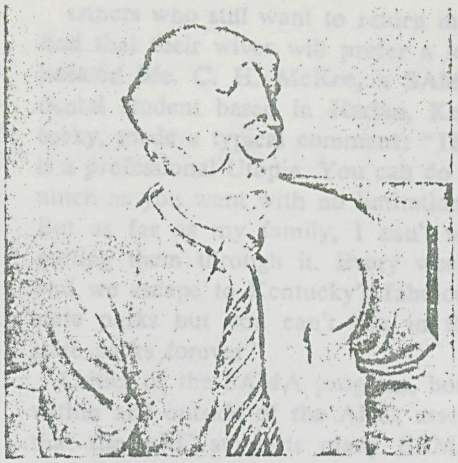
W. Grady Stumbo, a fourth-year medical student and program director for SAMA, explained SAMA's desire to avoid rocking the boat. "We're part of the system," Stumbo told *Science*. "Health care has always been in the professional community and it is going to stay there."

The Vanderbilt project, formulated by two Vanderbilt Medical School students, is now in its first summer. The group consists of roughly 15 Vanderbilt undergraduates, six nursing students, seven nurses who have just finished Vanderbilt's 4-year program which confers the degrees of B.S. and R.N. at the same time, eight law students, and eight medical students, who are staging eight health fairs, each of which lasts 1 week. The Tennessee Valley Authority (TVA) has lent two medical trailer units and about eight of the TVA personnel for the summer. The larger TVA van has equipment for x-rays, electrocardiograms, blood tests, audiograms, and pulmonary function studies. The smaller van is used to give adult male physical examinations.

Field Workers Follow Up

The Vanderbilt group is divided approximately in half between field workers, who are for the most part undergraduates and nursing students, and those traveling with the mobile units. Field workers are assigned to teams of at least two in each community for the whole summer. In the towns, they set up or work with community groups to lay the groundwork for the health fair. This involves both recruiting available health professionals who will volunteer from the community or surrounding area, and working on publicity, food arrangements, and housing arrangements. After the health fair is over, the field workers assist in the necessary follow-up work. The law students, most of them field workers, show local residents how, for example, to get Medicaid and Black Lung benefits.

An exciting, aggressive atmosphere pervades the Vanderbilt group. The students work hard giving physicals during the day and processing patients' charts at night. Every weekend, the field workers and members of the mobile units coordinate their efforts as they camp at Tennessee state parks.



Robert Cooper, SAMA medical student.

After the tensions of a hard week's work, the group savors the weekend for various activities, including singing, drinking, and swimming together, as well as reviewing the week's work.

George Maxwell, one of the two Vanderbilt medical students who organized the project, revealed that besides a $32,600 ARC grant, the group scraped up an additional $54,600 from five other sources; the Field Foundation, the New World Foundation, the Macy Foundation, the Regional Medical Program, and a summer stipend for three undergraduate students from Vanderbilt University.

Ginny Solomons, who just finished Vanderbilt's 4-year B.S.–R.N. program, said, "We went through a traumatic period when we didn't know whether we'd get funded. It came to a point when we said, 'Hell, we'll do it anyway,' because we became so excited." Their occasional midnight requisition parties have yielded free medical supplies. A wheelchair stamped "Vanderbilt University Hospital" is evidence of the "Beg, borrow, or steal" philosophy to which the group subscribes.

The Vanderbilt students have been well received by the communities where they have worked. In addition to housing the field workers who stay in their towns for the whole summer, residents of these towns have taken in many of the students with the mobile unit during the week of the fair. The fairs use community people to take histories, test eyesight, measure height, weight, and blood pressure. Some local men contribute by providing transportation. Clon LeMar, a 63-year-old resident of White Oak, said, "I enjoyed so much hauling the people back and forth. I hate to see these people leave."

The Vanderbilt physicals are very against diphtheria, whooping cough, and tetanus and are tested for tuberculosis and histoplasmosis. Blood samples are analyzed for cell counts, hemoglobin, inorganic components, and venereal disease. Pulmonary function studies are done on miners. Women are given Pap smears to test for cancer, and everyone over 21 is given a chest x-ray and an electrocardiogram.

TVA personnel, like the local residents, have good relations with the Vanderbilt group. James B. Pulliam, chief of the TVA mobile units, indicated that he and the other TVA men do not mind the strain of working overtime and processing many more people than they would during a regular work day. He commented, "I've never seen people more enthusiastic than those in this group, and it's a pleasure to be with them. They are doing a heck of a lot more than they could in school."

Learning to Give Physicals

During the school term last spring, Vanderbilt nursing students did extra studying to learn how to give physicals. They received further training during the project's 3-week orientation program and now give complete pediatric and, at times, adult physicals. Although the mobile unit screens about 750 people each week, there is only one physician, Dr. Joseph Moss, who is with the unit for the whole summer. Moss just completed his pediatrics residency at the Vanderbilt University Hospital. To increase the project's medical manpower, the group recruits Vanderbilt faculty members and local physicians, nurses, and dentists to visit and help out with the project.

William Dow, a fourth-year medical student and one of the project's two organizers, emphasized the strong community support which allows his group to do what it wants. He told *Science*, "We caught a lot from people [certain physicians and officials] for permitting nurses to give physical examinations, but the groundwork we did in the community paid off. No one can touch us."

Dow pointed out that Vanderbilt University refused to sign all but one grant contract and that, for a sponsor, he had to rely on Dr. Amos Christie, retired chairman of the Vanderbilt pediatrics department. "Nevertheless," Dow said, "it's worth dragging all those people up here [Vanderbilt faculty members]" to interest them in the proj-

cet and the problems of the Appalachian communities.

At one of the Sunday camping meetings, which are exercises in self-examination, project member Rod Lorenz, who had spent the previous week at the Vanderbilt University School of Medicine, offered a thoughtful critique of the project. He said, "In some ways, we're practicing sloppy medicine. Our gowns are not laundered; hands are not washed between patients; the sheets are not changed between patients; we don't smell nice. We have sometimes made contemptuous and rude remarks about the faculty and the university [because of their lack of cooperation]. These comments get back. We have to have the medical faculty on our side." The medical students resolved immediately to use disposable gloves when examining patients and to change the gloves between examinations. The group as a whole resolved to hold back from verbalizing its resentment against the university.

When the Vanderbilt group had a health fair near the town where two SAMA medical students were located, the SAMA students dropped their regular schedules to join the Vanderbilt group. The two SAMA students became so excited about the Vanderbilt project that they spent most of the next 3 weeks traveling and working with the group.

In evaluating these two projects, the personal biases of this reporter will undoubtedly make some difference. In Tennessee, it was possible to spend 2 working days and a weekend living with the Vanderbilt group and examining every facet of their program. The Vanderbilt experience often made one want to participate rather than just observe. On the other hand, it was feasible to visit no more than ten people connected with the SAMA program because the 141 SAMA students are geographically so widespread.

The SAMA program is really 141 independent projects. It is a difficult program to assess because so much of the student's experience depends on his own initiative and on his preceptor. SAMA's most important goal is to attract future physicians and other health professionals to practice in Appalachia. At present, it does not seem likely that SAMA alumni will swarm back to Appalachia. Even though one-fifth of last year's SAMA students said at their debriefing that they might return to Appalachia (a very encouraging statistic), the enthusiasm of some will certainly wane.

Others who still want to return may find that their wives will prefer a less isolated life. C. H. McKee, a SAMA dental student based in Harlan, Kentucky, made a typical comment: "This is a professional Utopia. You can do as much as you want with no limitations. But as far as my family, I can't see putting them through it. Every weekend we escape to Kentucky's fabulous state parks but you can't live in the state parks forever."

Critics of the SAMA program, both within and outside of the ARC, assert that the ARC supports many SAMA students who experience nothing more than a "nice summer." They say that if the program is to have any chance for success, that it should take students almost exclusively from Appalachia. The problem, however, is that there are comparatively few students born in Appalachia who will become health professionals and that some of these are intent on practicing in an urban setting.

The Vanderbilt project, unlike SAMA, seems to be meeting its primary goal: working with grass roots organizations to plan a week of free comprehensive physical examinations. By the end of the summer, more than 6000 Appalachian residents, many of them children, will have benefited from the Vanderbilt effort.

The results of most lab tests are sent back to the field workers within a week or two after each health fair. The field workers then give priority to contacting and making treatment available to those patients with acute illnesses. In any one community, the names of those individuals who are acutely ill will be learned within a few weeks, and an effort will be made to get Medicaid to finance their hospital costs. A computerized statistical analysis on all patients' charts, with totals and cross tabulations, will not be available until late September.

Even without an extensive array of numbers, the accomplishments of the Vanderbilt group are evident. For example, children are being taught how to brush their teeth and are given free toothbrushes and toothpaste. Miners get help in applying for Black Lung benefits if TVA x-rays show that they qualify. Vanderbilt field workers make sure that at least those with the more serious ailments receive proper medical follow-up. But perhaps most important, the Vanderbilt field workers are strengthening eight community health organizations so that residents have increased confidence in fending for themselves.

In White Oak, for example, the local residents have formed a group which has obtained a commitment for a free, prefabricated clinic. Of course, White Oak is likely to have the same problem that plagues Jellico—lack of health manpower.

What the Vanderbilt group accomplishes for eastern Tennessee health care over the long run is still uncertain. Most Vanderbilt medical and nursing students, when asked whether they will return to practice in Appalachia, reply, "Who knows?" Nevertheless, for those interested in improving rural health care anywhere, the Vanderbilt group should provide a helpful model. In addition to Vanderbilt students' having created a program to which they are obviously deeply committed, the residents of eight eastern Tennessee communities will be more conscious of the importance of adequate health care and will be better organized to pursue their needs.—SAMUEL Z. GOLDHABER

RECENT DEATHS

Erwin H. Amick, 59; chairman, chemical engineering department, Columbia University; 9 July.

William J. Bowen, 58; chief, bioenergetics section, biophysical chemistry laboratory, National Institute of Arthritis and Metabolic Diseases, NIH; 28 July.

Thomas F. Bridgland, Jr., 43; professor of mathematics, Drexel University; 17 July.

Felton G. Clark, 66; former president of Southern University; 5 July.

Edward R. Collier, 75; former professor of social sciences, Boston University; 2 July.

W. Marshall Denison, 35; president, John Tyler Community College; 26 July.

Harris Fahnestock, 64; assistant director, Lincoln Laboratory, Massachusetts Institute of Technology; 26 July.

Richard Ford, 55; Massachusetts state pathologist; 3 August.

Jesse W. Fox, 63; chairman, chemistry department, Memphis State University; 8 July.

Louis C. Graton, 90; professor emeritus of mining geology, Harvard University; 22 July.

William E. Ham, 53; professor of geology, University of Oklahoma; 10 July.

VU, Meharry Medical Students

Youths Who Care Aid Those Who Need

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By FRANCES MEEKER

The mountain woman enters the school building down at the end of the road in Briceville, an old mining village at the foot of Cross Mountain. She leads a 10-year-old boy — the son of her daughter who has left the Southern Appalachian region to find work in Cleveland, Ohio.

With modesty and dignity typical of her age and region, she prepares for a physical examination. A young man in a white coat, too young to be a doctor, and a young woman, too young to be a nurse, begin with a tuberculin skin test.

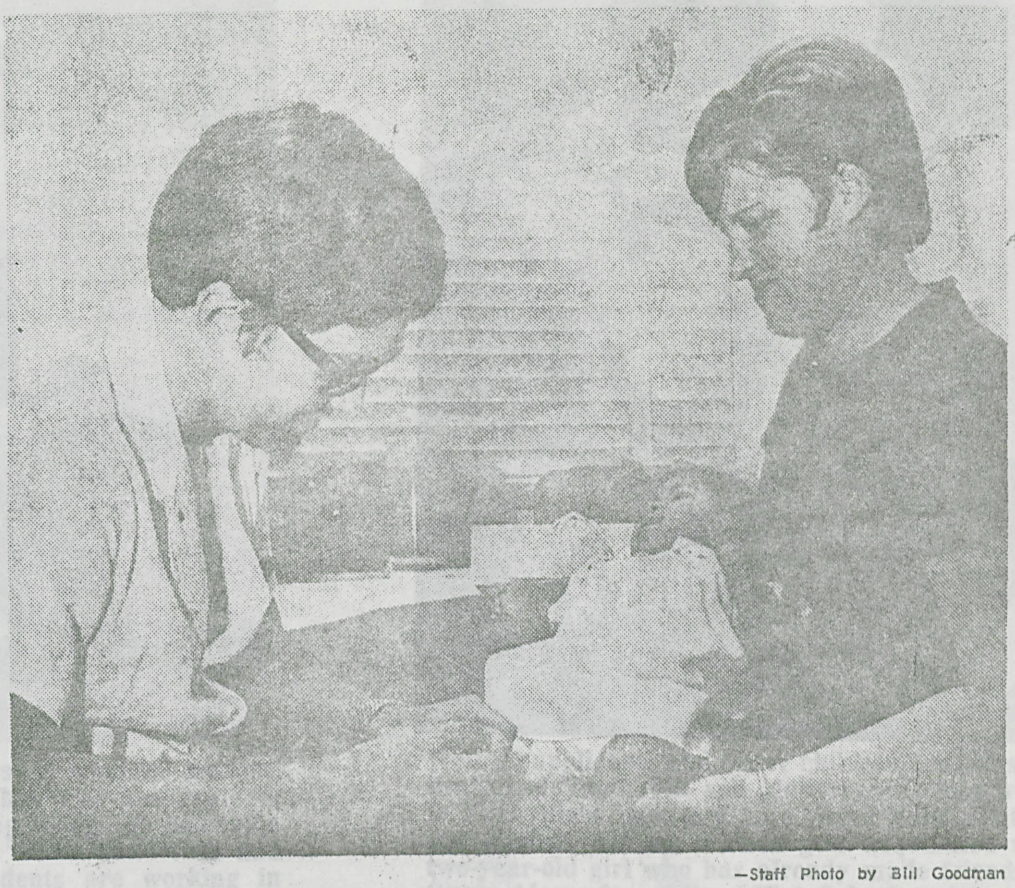
In another classroom, her grandson is undergoing a similar examination.

The young man in the white coat, a fourth-year medical student from Vanderbilt University, and the young woman, a Vanderbilt nursing student, talk with the woman after they examine her.

Test Result

From the results of their tests, they know she needs extended and costly medical treatment. She does not have the money to pay for it and she is too young for Medicare.

(Please Turn to Page 4, Col. 3)



—Staff Photo by Bill Goodman

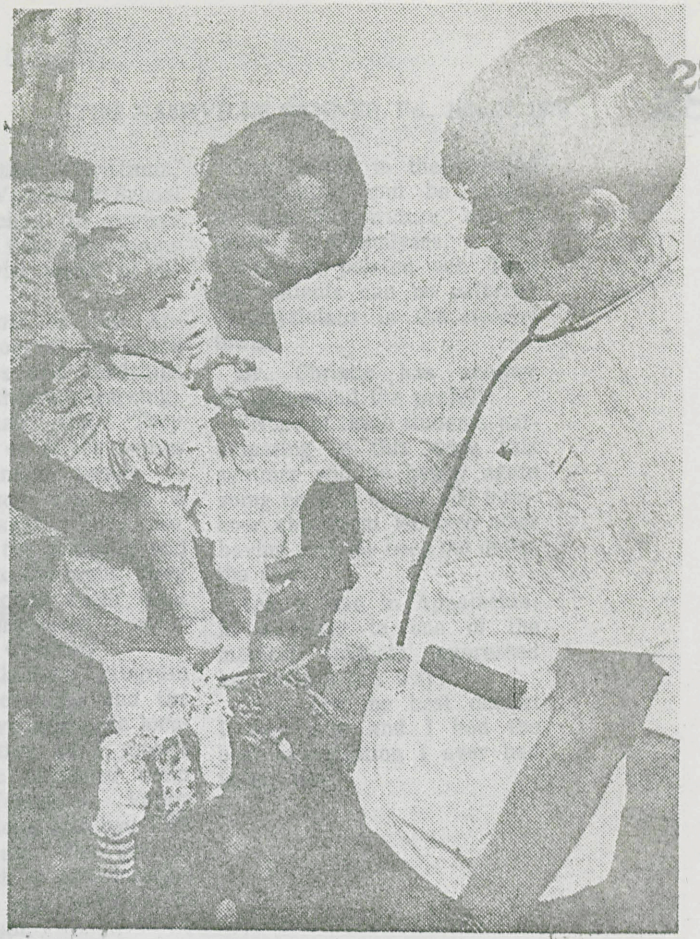
At a health clinic improvised in the Cumberland View Homes in Bordeaux, Clyde Heflin, Vanderbilt medical student, prepares to make a blood test on a child from a foster home who has been brought by Miss Patricia Odom, social worker with the State Welfare Department.

Helping Hands

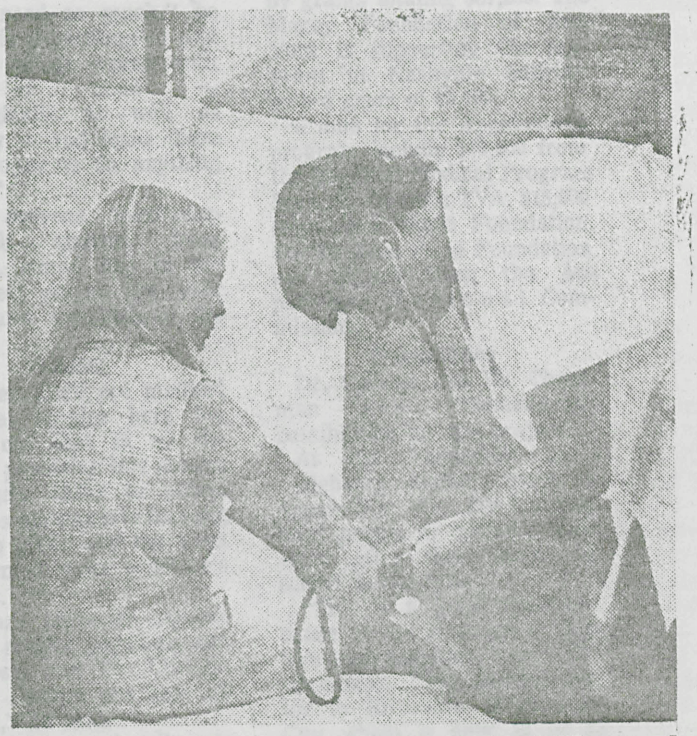
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Bill Dow, Vanderbilt University medical student, listens to the heartbeat of a boy who has come in from his home near the mining village of Briceville to get a physical examination while Vanderbilt and Meharry Medical College students are working in Appalachia on a health care-study project.



Welfare applicants and foster children are the special project of Vanderbilt and Meharry students working in Nashville's inner-city area. Here Vanderbilt medical student William Watson gets acquainted with a two-year-old girl who has already made friends with Queen Alexander, a Pearl High School senior working in the program.



This teen-age girl is one of hundreds of children and adults in Appalachia who have received medical examinations by Vanderbilt and Meharry students this summer. Her case will be referred to a private physician or to the public health and welfare departments. Pat Maxwell, Vanderbilt student, is taking her blood pressure.

Youths Who

(Continued From First Page)

The Vanderbilt students will help her solve her problems the best they can. They will take her case to the Anderson County Public Health and Welfare departments and get glasses for her grandson through a local service club.

At Bethlehem Center on Charlotte Avenue in Nashville, not far from the campuses of Vanderbilt and Meharry Medical College, a similar scene takes place. Two women medical students at Meharry are examining children who are wards of the State Welfare Department and are living in foster homes.

Other students are examining welfare applicants.

While the nation slowly recovers from a troubled academic year and waits apprehensively for the next, these medical and nursing students from Vandervilt and Meharry are conducting quietly a dramatic humanitarian program in Appalachia and in the inner-city area of Nashville.

Fifty-one students from the two nationally-known schools here are working in the desolate coal-mining region of East Tennessee. The students are involved in the problems of the region — the lack of medical care, the need for legal aid and the knowledge that there must be a better way of life.

Eleven students are working in community centers in Nashville, finding much the same problems in an urban setting.

Called the Student Health Coalition, the program was initiated and planned by the students and is actually an "on the job" training program for future doctors and nurses.

Health Care

The program could lead to new and effective ways to provide health care for the poor as well as revolutionary changes in medical school programs, says Vanderbilt pediatrician, Dr. Amos Christie, who hovers over the work like a proud father.

And yet, the idea is not as revolutionary as it may seem at first glance, Dr. Christie maintains. He serves as faculty adviser, preceptor and "principal investigator."

The students are working with the patients under the supervision of Dr. Christie and other doctors from Vanderbilt and Meharry much in the way doctors were trained in this country up until about 50 years ago.

"We can talk for as much as a hour with the patients that come to us and can really get to know the problems facing them in getting the medical care they need," said William Watson, second-year Vanderbilt medical student from Milwaukee, Wis.

Margery Scott and Sandra Bates, Meharry medical students, feel fortunate to be working both with adults and children at the same time, an experience they do not get in hospital work.

Opportunity

"It is also an opportunity for us to learn what health care is available and how to get it," said Miss Scott, a fourth-year student from Portsmouth, Va. They usually refer their patients to Matthew Walker Health Center at Meharry or to General Hospital.

"I like to feel that I am rendering a service to the community while I am learning," is the way Miss Bates, a third-year student from South Boston, Va., expresses her feeling for the program.

The foster children who are brought in by social workers present a "real challenge" to Joe Holliday, second-year Vanderbilt student from Chattanooga.

"They need so much," he said. "It is frustrating to find so many things wrong with many of them — psychologically as well as physically — and know there is not money to do anything about it."

Frank Stevens, third-year Vanderbilt student from Nashville, would like to see the project go on the year around and not just in the summer.

Tangles

He noted there are medical and legal tangles here but pointed out that in all the states, a physician has powers to delegate tasks to others so long as appropriate training has been given and the work is performed under a doctor's direction.

"We are perfectly capable of doing routine physicals and other tests and Dr. Christie or other doctors are here all the time," he said.

This would greatly alleviate the load on doctors and clinics, he pointed out.

Both Dr. Christie, who has retired as chairman of the Vanderbilt department of pediatrics but continues to teach, and Dr. Luther Christman, dean of the Vanderbilt School of Nursing, cited the project as one of the best expressions of the "activist spirit' of today's youth.

The students in the Appalachian program disregard the handicaps and hardships under which they are working, Dr. Christman said. 'They live in tents or in the homes of the mountain people — wherever they can find a place," he said. "They are up early in the morning and work late into the night. They are very excited about what they are doing."

Six Counties

The Appalachian program covers six counties and the students move from one location to another in a mobile health clinic furnished them by the Tennessee Valley Authority, along with two TVA staff members. The groups spend a week at each location and leave two workers to follow through.

The Nashville program has a regular weekly schedule of visits to Bethlehem Center, Cumberland View, I. W. Gernert Homes, Sam Levy Homes, Meharry Comprehensive Health Center and Senior Citizens Center.

The entire project is funded by grants totaling $87,200. The Macey Foundation of New York is supporting the program in Nashville entirely with a grant of $9,600.

Grants for the Appalachian program include $10,000 from the Regional Medical Program here, $5,000 from TVA, $15,000 from New World Foundation, $15,000 from Field Foundation and $32,600 from the Appalachian Regional Commission.

Possibilities

Dr. Christie and Dr. Christman see "tremendous" possibilities for the project.

As the Vanderbilt and Meharry students work in Appalachia, they are training local people to continue their work after they return to school in the fall.

"This is a great need because of the shortage of doctors and hospitals," said Dr. Christman. "The nearest doctor to Briceville is in Lake City which is only 12 or 15 miles away but for people who have been deprived of medical care perhaps all of their lives, the psychological distance is greater."

The people in the isolated communities can be taught to take temperature, and to make urinanalyses, Dr. Christman pointed out. Then the patients can be referred to physicians in the nearby towns.

Dr. Christie has another thought about the project:

"None of these students participating in this work this summer will be happy again going back to books and four-hour classroom lectures after having actually been out doing the work."

And a man in Appalachia, in a letter to one of the medical students, expressed his feelings this way:

"You are the best doctor I ever saw and I had the best examination I ever had in my life."

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VU Students Spread Health Awareness In Eaststate

By WILLIAM GREENBURG
TENNESSEAN Science News Writer

BRICEVILLE, Tenn. — Pat Maxwell sat down to supper here the other day and — between hurried bits — discussed the work which has kept him and other medical students busier this summer than they've ever been.

He didn't have long, he explained, because he had to get back to work. He had already been working nine hours but the long day was far from over.

JUST A short while before, Maxwell's examination of a 63-year-old Briceville woman had disclosed a heart murmur so loud "it could be heard across this dinner table."

But the examination was only the first step. Now, he explained, steps were under way to get the woman the medical help she needed so badly.

Other Vanderbilt University students from the schools of medicine, law and undergraduate faculties passed in and out of the cafeteria at Briceville Grade School. They ate hurriedly and then returned to their work.

THE 46 Vanderbilt students here — and a few colleagues from other universities — have been maintaining a hectic pace all summer.

They have been conducting a "Health Fair" in remote communities of the once flourishing East Tennessee coal fields between Knoxville and Jellico.

The Health Fair lasts for one week in each community.

During the week of the Health Fair the medical students give complete medical examinations under the supervision of local physicians and Vanderbilt medical faculty to all comers.

THE STUDENTS render no care.

Their primary mission is to make sure that when the Health Fair leaves, the people will get the proper medical attention.

More important, the students want to plant the seed of health awareness in each community so the people will band together in health councils, build clinics and attract regular medical care by doctors and nurses.

THE STUDENTS have so far this summer worked in Murfreesboro, and Smithville. Then they moved to the upper coal region in the Cumberlands and worked in Clairfield, White Oak and Briceville. They will finish out the summer in Sneedville, Habersham and Deer Lodge.

They are working under grants totaling $87,200 from the Macy Foundation, The New World Foundation, The Field Foundation, The Regional Medical Program, the Appalacian Regional Commission, and the Tennessee Valley Authority. TVA is also providing supplies and the use of its staff and a mobile multiphasic screening unit.

The Vanderbilt project recognizes that the doctor's role is only one part of health care.

FOR EXAMPLE, after explaining how serious the woman's heart ailment was and how Dr. Edward J. Battersby, assistant professor of medicine and cardiac specialist recommended immediate action, Maxwell reflected on the new dimension by young doctors that goes beyond treatment of disease.

"This woman is 63 years old," he said. "She has two daughters, the youngest of which is 18. This means that the woman is no longer eligible for welfare under Aid to Dependent Children.

"She informed the Welfare Department about this and luckily they did not cancel her promptly. She has received her check for this month. This means she still is eligible for Medicaid until the middle of August.

"WE MUST get her to the Knoxville Cardiac Clinic before her benefits run out. She can not afford needed care and it will be two years before she is eligible for Medicare. Then it will be too late."

Getting the woman to the cardiac clinic and others like her to needed services is the job of students who are the follow-up personnel.

One of these is Miss Karen Blaydes who just graduated from Vanderbilt undergraduate school and who will teach high school in Atlanta.

"John Davis (another VU undergraduate) and I arrived in Briceville June 16," she said. "We got to know people in the community and began to muster support for a health council. We arranged for accommodations for the Health Fair people. One of the most important tasks was to find out what resources the community had particularly in transportation."

THERE IS evidence that the students' effort to muster interest and spark action by the communities has taken hold.

Byrd W. Duncan Sr., a miner for 20 years is head of the Briceville Health Council. He said the demand for the health examination has been overwhelming.

The students have been seeing about 200 people a day from Briceville and the surrounding areas.

"Briceville was a mining camp," Duncan said. "There were doctors here and when you needed one you could get him to come to your home. When the mines close, the doctors left.

"TO GET a doctor now," Duncan continued, "you have to go to LaFollette, Oak Ridge, Clinton or Lake City. You can't just see a doctor any time. It's like going to a mill to get your corn ground. You have to wait your turn and its crowded."

Duncan said the people in Briceville are interested in getting a doctor for the community and the nearby hollows. He said an officer of the Anderson County Health Department put the community in touch with the Vanderbilt students.

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"The people (of Briceville) were at first. They have a lot of pride. They don't like to ask for help. I convinced the people that health care is not charity and if they let the students and the TVA units come they could all get a complete physical examiniation," he added.

DUNCAN SAID that health council meetings have been scheduled and dicussions will be held on how to finance the building of a clinic.

Miss Ann Baile, who just graduated from Vanderbilt nursing school, said the White Oak Community has already taken steps to insure regular health service.

She said White Oak has formed a health council and has acquired land for a clinic. She said the community is negotiating with contractors to clear the land and to build a clinic.

MISS BAILE added that Dr. Nicholas Gerber, instructor in pharmacology at Vanderbilt, has volunteered to service the White Oak Clinic once a month.

One of the toughest probblems the students have encountered is how to finance follow-up or long-range care for people who do not qualify for aid.

It is in this area that the law students help.

BOB WHITE, from Columbia University, said the job of the six law students is to channel the people to available health care programs.

"Some people have some type of hospitalization or veterans benefits that they have forgotten about and we have to find out about these things," said Miss Jane Evins, a Vanderbilt law student. "We also advise about food stamps. It's more like social work but you must know about programs and regulations."

The Vanderbilt students have been working a long time on the program.

IT WAS CONCEIVED by medical student Bill Dow two years ago. Last summer, Dow and Maxwell had the same program on a smaller scale in Williamson County. Also, they conducted a pilot program in the East Tennessee coal region.

After two years of work, it appears for the students that the day never ends.

It was about 9:30 in the evening when a car pulled up to the Briceville school. The students were checking medical records after a day of examinations.

THERE WAS a family in the car and a young man emerged looking pale and drawn.

The man was Dick Burr, a Vanderbilt undergraduate, who had been working at Deer Lodge. A family had driven him all the way through the mountains.

The students hovered around Burr and immediately called Dr. Joe P. Moss. Moss, who just finished a stint as chief pediatric resident at Vanderbilt, will take over the pediatric division at Metro General Hospital this fall. He is working with the students the entire summer.

MOSS QUICKLY diagnosed the ailment as intestinal flu and administered medication. Moss then prescribed and "extended" rest for the evening.

Burr would be ready for action the next morning. The other students went back to the medical records as one day ran into another.

VU Program To Produce 'Family Doctor' Nurse

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By WILLIAM GREENBURG
TENNESSEAN Science News Editor

Vanderbilt University has started a program that will produce nurses trained in the role of the family doctor to work in areas where health care is lacking.

The graduate program is in a pilot phase involving two registered nurses and a $35,000 grant from the Appalachian Regional Commission through a contract with the Frontier Nursing Service in Hayden, Ky.

THE CURRICULUM called the Community Health and Family Nurse Clinician Program, is directed by Dr. Beverly Bowns, a professor in the Vanderbilt School of Nursing. The program is a cooperative effort with the school of nursing, the Vanderbilt School of Medicine and the John F. Kennedy Center for Research on Education and Human Development.

The evaluation of a nurse practitioner to take on the role of a family doctor in rural and ghetto areas where health care is not available has been in the development stage the last 10 years.

The impetus for the Vanderbilt program, however, came from activities of the university's student health coalition which provided screening examinations and the mechanism for follow-up and community initiated health services in a number of rural areas in Middle and East Tennessee last summer.

"THE REAL point of our work during the summer is that we as nurses realized we could have a much more expanded role," said Betsy Weil, one of the students in the new program and a student health coalition nurse during the summer project.

The other student in the new program is Kathleen Arganbright, a public health nurse who served with the Peace Corps in India.

During last summer's project, upperclass nursing students from Vanderbilt were doing physical examination along with medical students.

THE NURSING students took an intensified short course last April beginning with home nursing at the American Red Cross Center. Their preparation included studying problems of pregnancy and screening for abnormalities during physical examination, supervised by Dr. Amos Christie, professor and chairman emertius of pediatrics.

Christie is the founding sponsor of the health coalition.

Miss Weil said the summer's experience demonstrated that nurses could do diagnostic work. She added, however, that the work was more in the role of a physician's assistant working as an extension of the doctor.

"THE NURSE in our new program will be capable of doing primary care anywhere," said Dr. Bowns. "The aim of this program is to turn out a nurse who is an independent agent and at the same time able to be a part of the new scheme in health care delivery. Our concern is not that the nurse will be doing the same thing as the M.D. We are interested in filling the health care gap."

While Miss Weil and Miss Arganbright are taking courses in the new program that will lead to a master of science degree in nursing, they are aiding in constructing the curriculum under supervision by the medical and nursing faculties.

The two nurses are taking advanced physiology, clinical diagnosis, pharmacology and statistics. In clinical course work they are working in the Vanderbilt pediatric and adult outpatient departments. Also, they are doing screening with medical students and Dr. Christie in a Nashville day care center.

WHILE THEY are taking courses, Miss Weil and Miss Arganbright are working on formulating other subjects including diagnosis and history taking, comprehensive family practice, human growth and development in childhood and maternity nursing, including midwife training.

"We want to develop a nurse who will develop a great deal of sophisticated diagnostic and clinical skills. This nurse will primarily be trained to develop a program to maintain health and prevent disease rather than disease management," explained Dr. Luther Christman, dean of the Vanderbilt School of Nursing.

anderbilt, Meharry med schools aid foster kids

By BILL CRAFFORD

This summer the medical schools of anderbilt and Meharry jointly participated n a medical assistance program within the letro-Davidson County area. Under the ominal supervision of Dr. Amos Christie f Vanderbilt and Dr. Leslie Falk of leharry, a biracial group of medical udents gave physical examinations to 92 pplicants for welfare disability and 194 oster care children.

The Vanderbilt-Meharry Nashville-ased project, under a grant from the lacy Foundation, had those two groups as eparate health care target groups.

Foster care children are those who have een removed from their natural families r reasons of neglect, abuse, desertion, financial disability. The Tennessee State epartment of Welfare then places these ildren in foster homes until the situation corrected in their original homes.

"From the cigarette burns all over eir bodies to their broken bones, one can ally tell some of these kids have had it etty bad," said Joe Holliday, second-ar Vanderbilt medical student and pro-am participant.

"A lot of them have been beaten and one ild had been sexually assaulted by his ther," he recalled.

Many of the children had been so badly istreated that there was evidence of emo-nal damage as well as physical, said Holliday and Bill Watson, another second-year medical student. Due to the high salary of a child psychiatrist, however, the State Welfare Department could not afford to hire professional help for these children.

After examining and testing 194 children, the group reported that "92, or 47 percent of those tested had significant medical problems. Four children had organic heart problems which had not been followed up previously. Approximately 75 percent of the children examined needed some type of immunization . . . both oral hygiene and personal hygiene were poor. . . ."

Watson reported "there were some children who were completely submissive, showing no expression, no emotion, no feeling. Even when we gave them injections there was no response."

Based on their findings the group of nine medical students and four volunteers sent recommendations to the Tennessee Department of Welfare, key among which were:

— the hiring of a child psychiatrist or clinical psychologist

— the regular examination of each child by a licensed physician

— proper completion of necessary immunizations for each child

— maintenance of up-to-date medical records for each of the foster children.

Watson and Holliday were shocked at the number of "really sick people who needed medical attention but didn't know what to do, how to get it, or where to go," among their welfare recipient patients.

Most of the cases were between 50 and 60 years old, suffering from chronic illnesses with multiple complications. Often the applicants had been waiting for further applications to be processed when they needed immediate attention.

"It's hard for them to get treated for all their ailments at one time," said Holliday. "A lot of times they just give up because of all the red tape and all the different specialists they have to go see. It's often too big for them to comprehend."

Again recommendations were made to the State Welfare Department and the Metropolitan Public Health Department. Of particular concern were:

— immediate treatment of needy patients

— issuance of welfare M-50 forms to licensed physicians for completion by them rather than just by the Welfare Department physician

— requirement of chest x-rays in physical examinations

— shortening of time for application processing

— furnishing of a public health nurse to make sure each patient arrives at his appointment

Among the participants, reaction to the program in Metropolitan Nashville emphasized the organization and planning by the students and not by the faculty or other supervisory organ.

'Forgotten Hollows'

VU Student Efforts Give White Oak Health Clinic

By WILLIAM GREENBURG
TENNESSEAN Science News Writer

WHITE OAK, Tenn. — The only thing that kept the landscape, scarred by strip mining, from looking like the moon was the downpour that filled the craters formed by slag mounds with water.

The rain was also pounding the new shiny white trailer as the specially designed structure received its baptism as a health clinic.

It is the first health facility in this tiny hamlet northwest of Knoxville near the Kentucky state line since the area thrived as a mining center and the coal companies provided the doctors.

DR. ERIC CHAZEN, president-elect of the Nashville Pediatric Society, who has volunteered his services, was participating in the dedication of the clinic that Vanderbilt University students helped start, by coping with a man who was walking around with enough suspected severe disorders to floor a professional football team.

Chazen is one of a number of Nashville, Vanderbilt and Knoxville doctors who it is hoped will serve the clinic on a rotating basis. The clinic is served also, by Sister Alcia, a registered nurse from Jellico, Tenn., Mrs. Ruth King, a licensed practical nurse and Mrs. Wanda Marlow, a medical secretary, both from White Oak. Money for Mrs. King and Mrs. Marlow has been provided by the regional medical program, but it will run out in November.

CHAZEN WAS sitting on one of the cushioned benches in the waiting room outlining problems of health care delivery while waiting for some blood test results on his patient.

"I think we are running in this country, an infant mortality rate of about 15 deaths per 1,000 births. That's not good," Chazen said.

An older man, years in the coal mines, sitting next to Chazen interrupted.

"Doctor, I'm not real sure but I think it's 17. But whatever it is, it's double here," the man said.

The White Oak Medical Clinic was open for business.

The clinic is one of the first tangible results of a two-year effort by Vanderbilt medical, law, and undergraduate, students called the Student Health Coalition to light a spark for health, dignity and development in the forgotten hollows.

THE VANDERBILT students conducted weeklong examinations in a number of communities in the Applachian mining region. The main idea was to see that health care continued after they left through organizational efforts of the communities.

"It all happened between July when the Vanderbilt students got here — we'd be nothing without Vanderbilt — and today. And that's a great step," said Fred Haynes, a preacher, who has black lung disease from 25 years in the coal mines.

"It doesn't hurt. I take a pill every morning," Haynes said, about his ailment.

The clinic almost did not become a reality when the arrangements to secure a building fell through. The story was related in the one and only edition of a paper from the area called the Model Valley News.

ONE OF THE recipients of the paper was a LaFollette, Tenn., merchant who became excited about the work students from his alma mater were doing.

Sam Balloff, Vanderbilt '48, secured the trailer. He will now devote energies to securing the interest of Vanderbilt alumni to provide more badly needed help in the region he traveled as a boy in the 1930s, passing out circulars about sales in his father's clothing store in LaFollette.

"I guess the Model Valley News went to all rural box holders. It made me mad to know this (lack of health care) was going on in my back yard for years," Balloff said.

SSEAN Sunday, October 18, 1970



—Staff photo by Jack Corn

Thriving Mines---And Now This

WHITE OAK, Tenn. — An abandoned automobile and refrigerator serve as fitting props for the landscape laid bare by strip mining in East Tennessee near the Kentucky statel ine.

VU Students Aid 2 Towns In Appalachia

By WILLIAM GREENBERG
TENNESSEAN Science Writer

Vanderbilt University students, with the aid of the U.S. Geologic Survey, have designed water systems for two remote communities in the Appalachia region of the state.

The work was part of a summer program that brought medical, nursing, law, engineering and undergraduate students from Vanderbilt into rural Tennessee communities where they started programs to bring in permanent health services.

THE VANDERBILT group, still active, is called the Student Health Coalition. It tackled the medical lack of care by stressing health maintenance, as well as curing disease.

A major aspect of comprehensive health maintenance is pollution control.

While most of the students were engaged in giving physical examinations, Charles Schiff from the department of environmental and water resources engineering under the guidance of chemistry professor Dr. David Wilson were giving bacteriological examinations to the water wells.

WILSON AND Schiff worked in White Oak and Clairfield. These communities are almost due north of Knoxville, east of U.S. 25W near the Kentucky state line.

The task that Wilson and Schiff were confronted with was monumental and a monument to years of mining exploitation without regard to the rudiments of public health.

"We tested 130 wells for fecal bacteria and found about half of them infected. We told the people to boil their water and take other precautions," Schiff said.

SCHIFF EXPLAINED that wells were near privys, well shafts leaked and underground and strip, mining operations endangered whatever water was available.

"The blasts from the strip mining damaged the pipes used for well shafts. Also the blasts changed the natural contour of the earth affecting the flow of underground water," Schiff said.

Schiff said that White Oak is completely undermined with coal mines. He said that people now are driving six miles to truck in water from a polluted mountain stream.

He said that many of the wells ran dry years ago when the mines were dug and drained off the subsurface water.

SCHIFF SAID that the U.S. Geologic Survey sent a team from Nashville to determine how to build water systems, for both communities.

"We were lucky in White Oak. We found an adequate supply of water running out of the mouth of an abandoned mine at a highelevation. At first you would think that the water would be polluted. I guess that from years of flowing you might say the mine had been rinsed. The survey team tested the water and found it fit," Schiff said.

Finding a source of water in neighboring Clairfield was more difficult.

Schiff explained that the survey team followed mineral concentrations and used contour maps. Mineral concentrations usually mean that they have been washed into an area by water, Schiff said.

HE SAID that a good source of water was found that passed the survey team's tests.

The project now is faced with its most difficult obstacle. Money must be found to build the water systems.

Schiff said that the biggest expense for each system is the cost of pipes from the source of water to each home. Only Clairfield, he continued, needs a pump because gravity will take care of the flow in White Oak.

Environmental and water resources engineering professor, Dr. Frank Parker, said that a survey would have to be made to find out how much the water systems will cost.

Pressed for an estimate, he said that for communities such as Clairfield and White Oak, water systems could run between $50,000 to a bit under $100,000 each.

PEDIATRIC ELECTIVES

1970-71

METHODS OF DELIVERING PEDIATRIC MEDICAL CARE IN RURAL AREAS. 3 hrs/wk, 6-wk. units, 1st, 2nd, 3rd, 4th years.

In planned sessions under faculty supervision, working visits will be made to rural areas near Nashville where opportunities will be available to participate in the activities of health personnel providing child care in clinic and home settings. (Drs. Karzon, Christie, and Staff)

URBAN HEALTH PROBLEMS. 3 hrs/wk., 6-wk. units, 1st, 3rd, 4th years.

Opportunity is provided to study and participate in problems of delivery of health care to the urban poor of Davidson County. First-hand observation of the problems of Health Care Delivery Services (e.g., Medicare, Medicaid, food supplementation, Welfare, availability of services) will be explored. Students will be encouraged to be active participants in the initiation and implementation of their own programs. (Drs. Karzon, Christie and Staff)

CLERKSHIP IN RURAL HEALTH. Full-time, 6 wk. units, 4th year.

The clerkship provides the opportunity to study and participate in health care in rural areas, including Appalachia. Opportunity will be offered to work with the people in rural poverty areas and the facilities and personnel concerned with health care. Students will be encouraged to be active participants in the initiation and implementation of their own programs. (Drs. Karzon, Christie and Staff)

AUG 3 1970

THE APPALACHIAN REGIONAL COMMISSION
1666 CONNECTICUT AVENUE
WASHINGTON, D.C. 20235

OFFICE OF
FEDERAL COCHAIRMAN

August 26, 1970

Dr. Alexander Heard
President, Vanderbilt University
Nashville, Tennessee 37203

Dear Dr. Heard:

I want to tell you of the Commission's enthusiasm for the Vanderbilt Medical School Student Coalition in Community Health Programs which we have assisted in funding, along with the Tennessee Valley Authority, this summer in eastern Tennessee. We are naturally interested in student-directed involvement programs in the region, especially health science student involvement programs, but we are especially enthusiastic about this particular project because of the potential that it has demonstrated for delivering health services to needy persons in isolated rural areas in the Appalachian mountains.

Several members of our staff, including two health systems evaluators, have shared their favorable reactions to the project with me and recommended that we take a close look at the possible followup and expansion potential of this endeavor. I have asked our staff to explore this possibility with Bill Dow and Pat Maxwell, the student directors, and with Dr. Christie and Dr. Karzon of the Pediatrics Department.

I just wanted you to know our feelings about this undertaking with your university and to say that we look forward to other areas of mutual cooperation in the development of Appalachia.

Sincerely,

John B. Waters, Jr.

John B. Waters, Jr.
Federal Cochairman

xc L. Christie
L. Karzon
Leon Bateman
Pat Maxwell

THE FIELD FOUNDATION
100 EAST 85TH STREET • NEW YORK, N.Y. 10028
212/535-9915

August 12, 1970

Amos Christie, M.D.
Professor of Pediatrics Emeritus
Vanderbilt University
Department of Pediatrics
Nashville, Tennessee 37203

Dear Dr. Christie:

Thank you very much for your letter of August 3. Coincidentally, I was the next day visiting the Health Fair in Habersham and the home of Mr. Byrd Duncan in Briceville. It is imprudent of me to say so, but I am full of admiration for these young men and women and the job they are doing.

My very best to you. I'll share your letter with Milton Senn, and we shall both look forward to the final report.

Sincerely yours,

Leslie Dunbar

/id

Regional Medical Program

1100 BAKER BLDG. • 110 21ST. AVE. S. • NASHVILLE, TENN. 37203 FOR TENNESSEE MID-SOUTH

office of the director
PAUL E. TESCHAN, M. D.

October 8, 1970

Thomas Findley, M. D.
Area Coordinator
11-12 Henson Hall
University of Tennessee
Knoxville, Tennessee 37916

Re: Evaluation of Project Outreach 1970

Dear Tom:

Many thanks for your comprehensive survey among people in contact with Project Outreach. I am taking the liberty to forward your letter to the Deans at Vanderbilt and to Dr. Christie, Dr. Karzon and Mr. Bill Dow for their information.

With best regards,

Sincerely yours,

Paul

Paul E. Teschan, M. D.
Director

cc: Dean Chapman
Dean Batson
Dr. Christie
Dr. Karzon
Mr. Bill Dow

PET:psk

11-12 HENSON HALL • U OF T CAMPUS • KNOXVILLE - 37916

FOR MID-EAST AREA OF
TENNESSEE MID SOUTH

THOMAS FINDLEY, M.D.
AREA COORDINATOR
PHONE: 615, 974-2223

October 5, 1970

Dr. Paul E. Teschan, Executive Director
Regional Medical Program
1100 Baker Building
110 Twenty-first Avenue South
Nashville, Tennessee 37203

Re: Evaluation of Project Outreach 1970

Dear Paul:

Miss Marie Cirillo of Clairfield, Dr. Charles A. Prater of Jellico, and Dr. George Day of Harrogate were on extended vacation when this survey was made. The following were contacted by telephone, however:

Dr. Ned Watts	Jellico
Sister Martha	Clairfield
Dr. Paul Spray	Oak Ridge
Dr. Parley Dings	Clinton
Dr. John S. Burrell	Lake City
Dr. C. C. Sexton	Lake City
Dr. Burgin Wood	LaFollette
Dr. R. C. Ellis	Harrogate
Dr. John C. Pryse	LaFollette
Dr. Alex Shipley	Knoxville

The degree of enthusiasm varied somewhat, but opinion was unanimous that the programs carried out last summer by Vanderbilt and SAMA were very much worthwhile. The students were accepted both professionally and socially by the residents, perhaps especially so in the Clairfield Valley. Several of the communities were stimulated to form permanent clinics of their own, although it was not clear where doctors could be obtained. Diabetes mellitus was perhaps the commonest abnormality uncovered by multiphasic screening, but none of the doctors reported significant overload of their practices as a result of the Health Fairs. Dr. Alex Shipley was distrubed by the fact that some of the Pap smear preparations were mislabeled, but even he approved of the program as a whole.

Tom

Thomas Findley, M. D.
Area Coordinator, Mid-East Area

DeKalb County
Neighborhood Service System
Room 5, Veterans Building
Smithville, Tennessee 37166

August 1', 1'70

Dr. Amos Christie
Student Health Coalition
Vanderbilt University Hospital
Nashville, Tennessee

Dear Dr. Christie:

I am taking the opportunity to write to you concerning the Health Fair held in DeKalb County by the Student Health Coalition. As the County's Director for the Neighborhood Service System Program funded through Stones River Economic Opportunity Commission, I would like to express appreciation to the staff of the Fair for giving so many of our low income persons the opportunity to receive a complete medical examination.

Needless to say, so many people, whether young or old, are not able to obtain physicals such as were given. For this reason many persons were found to be needing medical attention and were helped to receive such care.

DeKalb County is a small rural County with almost half of its population below poverty levels. Most of these low income people are clean hard working small farmers who do not consider themselves as underprivileged. This type of project gave them the opportunity for their entire family to receive a good examination without cost and yet not have the feeling they were receiving some type of "welfare treatment". This same thing is true with the very large percentage of elderly persons living in our County who have set incomes.

I know how very hard you and members of the Health Fair staff worked, and I know that all are respected and admired for the dedication that was plainly shown.

We had the feeling that the staff might have had some criticism as to so many elderly persons coming to the Health Fair and that most of them were under a doctor's care. In DeKalb County, we feel that very few people do not receive medical attention regardless of age or income when they are sick; but less, also regardless of age or income, receive a complete physical at any time.

We believe that perhaps in prior meetings before the Health Fair came to DeKalb County there might have been misunderstandings between both parties. We were under the impression that all would be welcomed at the Health Fair regardless of age or income. We were later told this was not true. I feel very few persons of the high income level were seen but, of course, there were some. We regret this very much if it were against your guidelines.

We enjoyed meeting and working with your people and sincerely hope that your staff might feel the same.

Sincerely,

Sheila A. Hobson
Director
DeKalb County
Neighborhood Service System

SAH:slf

STONES RIVER
ECONOMIC OPPORTUNITY COMMISSION, INC.
109 NORTH SPRING STREET
MURFREESBORO, TENNESSEE

Mr. Ben Hall McFarlin, Chairman
Judge L. Mitchell, Vice Chairman

Mrs. Harriet Haynes, Exec. Dir.
Telephone: (615) 893-8938

August 19, 1970

Dr. Amos Christie. Sponsor
Student Health Coalition
Vanderbilt Hospital
Nashville, Tennessee

Dear Dr. Christie:

We are submitting this report to you from all the Rutherford County OEO personnel that had the privilege to be involved in the McFadden Community Health Fair.

These are their responses to what they consider a most significant experience.

1. Publicity and Community Relations: We felt that the dedication the students displayed should have been more publically acknowledged through day-to-day coverage in the news media and meetings with civic groups.

   We would like to remind you of your promise to bring back information and members of the Health Fair to bring this to the attention of community people who would have been shocked if they had known 1,000 people turned out to obtain a no-cost health examination.

   We felt that cooperation between public health, OEO, education, private physicians, and private services was excellent. We wish that the Student Health Coalition members would recognize this as good community relations and not that we meant to "stack the cards" against their own community involvement.

   They will find many county communities in which the people in public health actually do not know the people involved in agriculture and education programs for the poor.

2. Services Rendered: We would like to give specific cases of the thoroughness of the Student Health Coalition medical examination.

"A four-year old who was born while his father was in the service had received pediatric care. But, the parents had never been informed of the child's heart murmur. It should be noted that the follow-up care for this child proved to be quite expensive. He was taken to Vanderbilt Hospital at a cost of $84 for one visit. This cost would be prohibitive to extremely low-income people."

"Another female adult reported that her examination was much more comprehensive than one she had spent $40 for a year ago in order to receive a Food Service Health Card. I knew this woman had inner ear troubles and asked if it was discovered in the examination, and she replied affirmatively."

3. Response To Health Fair: We were flabbergasted at the peoples who responded. When we went Monday morning we did not know if there would be two there or two hundred! To the best of our knowledge, only two non low-income people went through for an examination.

The outstanding job done by the members of the Student Health Coalition added to the response, as the word spread from day-to-day that this was a worthwhile venture and individual attendance held up and built up.

Without a doubt, the response proved need for comprehensive health examination services to low-income people in Rutherford County.

To our knowledge this is the first time that evening clinics had ever been scheduled for any health services in Rutherford County, including "sugar cube day for polio".

Again, the response demonstrated the need for schedules that fit low-income people who are either at work or without daytime transportation.

4. Volunteers: We would like to commend the Student Health Coalition for involving low-income people as volunteers in their very vital health experiences.

Our middle-class volunteers proved that the Health Fair is an excellent way to recruit for health careers (we could supply names and addresses of those who participated in order to keep in touch with those young people who might go into health services careers).

The volunteering by middle-income young people added another opportunity for them to come in first-hand contact with what it means to be poor.

I spoke recently at a women's club in which one mother stated, "I was so glad my child participated in the Health Fair. She learned things which she never would have believed without being a part of it."

5. Follow-Up: Follow-up had been excellently carried out by the Student Health Coalition. The Central OEO Staff has plans to take over follow-up where the students have left off.

We have been told that every Neighborhood Youth Corps student received a letter stating their health needs, and we have had calls from public and private agencies who are carrying out follow-up needs. Follow-up is a long, detailed and frustrating experience. Those who engaged in it successfully are to be complimented.

6. Legal Aid Services: It was brought out that the Legal Aid Team was responsible, through their in-service training for OEO outreach workers, for bringing to light one of the most critical needs of our present society. It was as follows:

> "A local cafeteria owner should have had his employees covered by Workmen's Compensation and did not. The same employer was deducting social security for the employees and not paying the employer's share. He was also paying employees in cash and not supplying W-2 forms."

It is likely that the Legal Aid Team should investigate what monitoring is done of smaller businesses and even franchise businesses to see that they are complying with employee benefits.

The in-service training that the Legal Aid Team held for OEO outreach workers was invaluable.

7. Recommendations: If the Health Fair should be repeated, and hopefully it will be, better food service should be provided by the community.

More health education could have been provided to the captive groups in lines waiting to be examined.

Art and music activities added immeasurably to the enjoyment of the Fair, though they did not hold up for the entire week.

OEO could have better used the services of the Legal Aid Team if we had known in advance that they were available.

We apologize for the length of this report, but we felt it best to be specific.

Very sincerely yours,

STONES RIVER
ECONOMIC OPPORTUNITY COMMISSION, INC.

Harriet M. Haynes

Harriet M. Haynes, Executive Director

jm

P.S. The Student Health Coalition group completely won over our community leader with the "worst bark" and demonstrated their maturity by having him "eating out of their hands".

Rutherford County
Department of Health
Murfreesboro, Tennessee
37130

September 9, 1970

Mr. Bill Dow
Box 49 Station 17
Vanderbilt University
Nashville, Tennessee 37203

Dear Bill:

This is in response to your request for our valuation and afterthoughts on the Student Health Coalition's Summer Project in Rutherford County and DeKalb County.

Very few folks in this area have nothing but praise for your operation in this county and DeKalb County. I am sure, however, that your group would be among the first to say that in Rutherford County, at least, where the program began your enthusiasm and open door policy resulted in your people being swamped and exhausted as well as leaving a few unseen patients disappointed. It is my understanding that this smoothed out as time went by and as you controlled your patient load.

As mentioned, the community reaction was quite good and consumer opinion has been quite high and positive.

The follow-up workers and their endeavors were a particular strength in your program. They apparently handled themselves with tact and efficiency and were, in general, well received by private physicians. Certainly, we appreciate their efforts and getting to us certain CCS eligible children. Too, we were happy to route children with visual defects who were eligible for Welfare assistance. At this writing, we still need to resolve the physical findings and work-up on a number of Headstart children as our CEO colleagues will need this information for their files. It is my current understanding that this get-together is being arranged.

We believe the quality of lab work-ups, physicals and diagnoses made were of admirable quality and we believe this opinion is shared by many private physicians. We are not aware of any problems that have developed with your referral patients either to private physicians or to the Department of Public Welfare. It is our further understanding that most of those Medicaid eligible patients that needed further medical attention did, indeed, receive it. We would certainly be interested in those who did not. Dr. Lois Kennedy, Murfreesboro, who

runs our local pre-natal clinic for low-income women, believes the work-ups were quite good although with her patients not too much pathology was found. She was impressed with the family approach of your Fair, that is, you provided an opportunity for a family constellation to receive rather comprehensive medical screening. We understand our own family planning patients who participated in the program were pleased.

I cannot accurately comment on the long term effects your project had on this community. Perhaps the screening period was, indeed, too short; it is likely that a screening program over several weeks would have quite a large impact. At this writing, I am not aware of too many startling problems your Fair did uncover. Hopefully, our medical community and our public agencies are, in general, aware of many of the problems your group helped confirm.

You are likely quite aware of a number of suggestions for improvement. Actually, I understand much of your procedure was modified as you progressed through the summer. Nevertheless, we would suggest that at the McFadden Community Center an indoor waiting area would be a great improvement over the outside quite warm facility you utilized. You apparently needed an increased number of examining areas to move traffic more rapidly. You should be assured of constant physician supervision at every moment in the future. You may wish to utilize a larger number of nursing students, as it is my understanding their performance was quite exemplary. It would help the local agencies if copies of your histories, physicals and laboratory findings could be prepared in triplicate so we could have quicker access to this material. Plan in the future never to over extend the physical capabilities of your young people; your troops, while in Murfreesboro, were uncommonly exhausted. In retrospect, there are many matters that your local hosts could improve upon I am sure; for example, we were a little late in thinking of your sleeping quarters and warm food.

I have talked to no one who would not welcome you back with open arms. Your group did a magnificant job and we are all most appreciative.

Sincerely yours,

Robert S. Sanders

Robert S. Sanders, M. D.
Director of Health

RSS:at

CLAIRFIELD COMMUNITY CENTER
Clairfield, Tennessee
August 21, 1970

Vanderbilt Projects
% Dr. Amos Christie
Vanderbilt Hospital
Nashville, Tennessee

To all Participants;

We in the Clairfield Community and at the Clairfield O.E.O. Center would like to thank you for bringing the services for our 1970 Health Fair. Without your support and help, our people would not have received the medical attention and diagnostic tests that they did. Many who were seen would never have the money for this, although they needed the medical attention.

Your group has done much to further the cause of better medical care in our area. You have helped bring aid and medical services to many who could never have this before, thus brightening their lives good repercussions will continue to come for a long time from the Health Fair team effort.

The community people and especially the staff of the Center are grateful to all of you for bringing much needed medical services for a brief time to our community. Again all we can say is THANK YOU.

Sincerely,

(Mrs.) Wilma Teague
Center Director

WT/pah

THE DANIEL BOONE CLINIC
MIDDLESBORO, KENTUCKY 40965

308

September 11, 1970

Bill Dow, M. D.
Box 49, ST 17
Vanderbilt University
Nashville, Tennessee 37203

Dear Dr. Dow:

This opportunity is taken to thank you and your group for the fine job done with the Health Fair at Clairfield this summer. It was well organized and the people went through the mobile unit without fuss or furor.

The work of this unit impressed the people of this community most favorably and the majority I'm sure were most grateful for the time and effort spent by your group in furnishing this exceptional valuable service.

Other than the patients, I am the one who has really profited in having the results of these examinations being made available to me. Most of these patients could not have afforded the cost of these tests and examinations if done elsewhere.

I doubt if 2% of the people of Nashville(other than those who have been in the hospital) have had the extensive examinations given here.

I whole heartedly join the people of the community in hoping that you and your group will return next summer to Clairfield.

Yours truly,

Chas. L. Kirkpatrick

C. L. Kirkpatrick, M. D.

CLK:cb

WHITE OAK HEALTH CNETER, INC.
R#1
DUFF, TENNESSEE 37729

Mr. William Dow
c/o Student Health Coalition
Box 49 St. 17
Vanderbilt University
Nashville, Tennessee

Dear Bill,

Thank you for helping us during the summer program, the thanks could never be expressed in writing or oral. But our community can say that without the help of the Medical Students this summer we never could have put forth such an effort and provided such services alone.

We also want to thank each and everyone for your continued concern and help.

This summer was such an experience that can never be forgotten for us and our young people who participated in the program, this helped us to understand our young people more and being with the Medical students has helped them to look forward to being more useful citizens.

Your Health Coalition Group impressed the community and a bond between the people was achived. Such as, People called us asking about students who examined them during the fair and ones whose homes were shared by the Students still ask about them.

Our community of White Oak voted Tuesday, September 22, 1970, to ask Vanderbilt Student Health Coalition, to return this summer for another H ealth Fair, they liked the plan put before them an acted at once. Therefore we hope you will return this coming summer with a more extended Health Fair, and we believe that it will be a greater sucess as we now have more experience in planning such an affair and that you have a plan that is even more extended then the past year.

Thank you again.

Sincerely,
Fred Haynes
Fred Haynes
President of the White Oak Health Center, Inc.

FH:Sb

Also nurse + (medical student) a follow up

OPEN HOUSE
White Oak Community Health Center
WEDNESDAY, OCTOBER 14
Starting 10:00 A.M.

Dear Friend,

I am sure you know how hard all the people of Model Valley have been working during the past several years to bring health services to the area.

It started with a group of people in Clairfield getting a clinic.

Several months ago, a group at White Oak got together to see what they could do. They did a lot. They started out with meetings. They had a busy summer conducting a health survey and health delivery program. Now they have two community people working part-time. Further support came from donations. Land, a trailer, and even some doctors have come our way. We will be ready for business Wednesday. And our business on this day is to celebrate.

COME JOIN US!

Fred Haynes, Chairman

White Oak Community Health Center

Hancock County Health Department

C. D. HUFFMAN, M.D. M.P.H.
DIRECTOR

P. O. BOX 102
SNEEDVILLE, TENNESSEE

We at the health department have heard many favorable comments on the Health Fair that was held in Hancock County July 27 through August 1. Just yesterday, a woman come in who was diagnosed as having a prolapsed uterus. She has since had surgery and is very grateful to the doctor who made the diagnosis and then visited her home three times to see that she got the necessary treatment. The follow-up work was excellent and the only problem seems to have been that some records were lost and did not get to the patient's doctor. We realize this was bound to happen with almost 1100 records.

There was some reaction to the slides that Mr. Finley had shown at the community meeting as many people felt that all of their physical would be done on the mobile unit and they were disappointed when they didn't get on the bus. This may seem trivial to us, but to them it was very important and just a matter of not being aware of what was going to happen. Most people knew about the Fair and the transportation schedule was good.

The only suggestion that we might have about the actual week of the Fair is that there be a little more time for orientation of the volunteers and a lot of this would be dependent on their coming on Sunday afternoon for an orientation meeting. The health department appreciated the list of supplies that were to be provided through this department.

There seems to be a definite increase in health awareness in Hancock County. We are grateful for this and the Health Fair was definitely a success.

Dear Bill and Pat,

I would say "your program" ran beautifully and that both of you should be highly commended for your efforts and for your success.

Two areas which might be considered a little more are 1) conditions - sterility or cleanliness, and 2) how to use length of wait more effectively. The conditions as far as clean sheets, drapes, gowns bothered me. I have tried to think of ways to change this. Paper products, gowns and drapes, might be a possibility although I realize the expense of this. Another possibility might be to try to solicit the aid of one of the townspeople to launder them daily. I guess an example of empathy might illustrate the importance of this. How would you feel, or what would your impression of the medical services to be rendered be if you had to put on a smelly gown and lie on a table with dirty sheets?

How important and how possible any change in waiting time is a question! I think it has plagued any kind of clinic. Could there be any preplanning along this line? Could a questionnaire or such be distributed in the town before the fair somes to get an idea of how many people might come with or without children and what day would be most convenient for them. With this information, you might be able to regulate the number of people to the medical facilities and the flow of people. One thing I learned this past year was that many appointments and having to wait a long period is a dehumanizing factor which often reinforces their poverty attitude.

Another idea which I have not worked out either affects the team. Everyone works very dedicatedly, hard, and for very long hours which could lead to "frayed nerves" and exhaustion. Your idea of rotating hours could help! I think it could be helpful to provide more free time so that the team could come back refreshed and eager to do a good job.

I am not sure what you learned from the woman in Social Work from Vanderbilt. I'd love to hear some of her ideas. I think this whole idea is essential to your program and to any medical program anywhere. I'll keep track of pertinent information that I learn this year and keep you posted of them. Also, I will try to get some workers for you for next summer.

Again I'm sorry I couldn't spend more time with you all. Hope that next summer doesn't have the complications. I felt I gained a great deal and enjoyed the people on the team. Also I found more respect for all those connected with Vanderbilt.

Peggy Price
Hancock County Public Health Nurse

ANDERSON COUNTY
HEALTH DEPARTMENT
STATE DEPARTMENT OF HEALTH COOPERATING
CLINTON, TENNESSEE

DR. P. M. DINGS, M. D.
DIRECTOR

313

September 25, 1970

Mr. Bill Dow
% Dr. Christie
Vanderbilt University
Nashville, Tennessee

Dear Bill:

Please excuse the delay in answering your letter of August 24, 1970. I did not see it until I returned on 9-11-70 and have been snowed trying to catch up. Consequently I have heard very little reaction from the communities involved as yet. At the end of the fairs they were very enthusiastic and appreciative and were trying to establish clinics or hospitals to attract doctors which I feel is impossible.

The mobile unit was very effective and provided lots of information that could not be obtained on routine physicals. The enthusiasm of the students was marvelous. They asked for and received support from Vanderbilt faculty and other physicians. Their willingness to work long hours to help poor people was expecially appreciated. It restores my faith in youth when I hear and read so much about riots, drugs, etc. I have not seen the follow-up workers since I was gone 3 weeks but the nurses have and it apparently was good. Some excessive referrals to County Judges for payment of medical fees which they can not do were made.

A good program was teaching volunteers to fill out forms, do simple tests-B/P, dip stick, etc. which increased their interest in health. I think, however, somewhere there was a breakdown which has slowed our nurses follow-up efforts. We are now receiving pap reports with names but no addresses or husbands name (Mary Jones, Duncan or Seeber may mean several people in Anderson County). U.T. Hospital also had difficulty identifying county to send them to and found many unnamed or illegible forms. The same is true in Campbell and Morgan Counties.

Our planning meeting in April failed to materalize so no requisitions for additional supplies were made. Consequently we ran out and could not get some. For example, the drug company has an order for 160 vials of polio vaccine (1600 doses) for the Briceville and Deerlodge fair which we have not received yet. I have to order at least 2 months in advance although it may come in 2 or 3 weeks. One never knows. Immune globulin is now unavailable from any source.

With early adequate planning and supply estimates, on the site training these minor problems (which seemed major at the time) could be eliminated.

Some questions have been raised as to whether this program is worth the time, effort and money (taxpayers) put into it. These cannot be answered until we know how much new disease was found. We will only have the ones referred to us. Perhaps you will have those referred to private physicians and we could share it. Probably it won't be answered even then because who can say the value of one early cancer cured.

I will be in Nashville at Cordell Hull Building in Dr. Farris office Thursday afternoon and Friday morning, October 1st and 2nd. If you are not too busy, maybe we could talk a little Thursday night or Friday afternoon.

Sincerely,

Parley M. Dings, M.D.

PMD/md

ANDERSON COUNTY
HEALTH DEPARTMENT
STATE DEPARTMENT OF HEALTH COOPERATING
CLINTON, TENNESSEE

DR. P. M. DINGS, M. D.
DIRECTOR

315

September 16, 1970

Mr. Bill Dow
c/o Dr. Christy
Vanderbilt University
Nashville, Tennessee

Dear Bill:

Here is the letter I promised you on my impressions of the Health Fairs you and your group held this past summer in Anderson, Campbell and Morgan counties.

First, I would like to comment on the young people from Vanderbilt who worked in this area this summer. Most all that I met were lovely and it was great to see the interest and enthusiasm they have. As you know, I spent 2 to 3 hours at each of the Fairs at Habersham, Briceville and Deerlodge. My overall impression was that everything appeared well organized and seemed to be accepted with enthusiasm by the people of the community from whom I have heard comments. People from the different communities were used to advantage and apparently were well trained to participate in functions they were capable of doing (vision screening with the Snelling E charts, urine testing using combistix, etc.) In addition, the students I observed who participated gave me the impression that each knew his or her function and was capable of carrying on that function. These comments are completely impressions as I was not involved enough to make a judgement.

I feel I did get a better impression of what your were doing by going through the Fair as a "patient" on my visit to Deerlodge rather than just observing the set-up there. I did that to get the "feel" of the set-up and certainly hope none of your group felt it was a "checking" situation. It is from this that I am able to say the above about the ones doing the tests and screening procedures. Incidentally, the student nurse who did the physical on me seemed to know what she was doing. As to her abilities to detect heart or lung malfunction, etc., I do not know as I do not know her background in these areas, but she gave me the feeling that she would be aware of her limitations and not exceed her capabilities - again I'm giving an impression and not a statement of a fact.

I do have other comments to make regarding the Fairs. The nursing staff in each of the local health departments involved was prepared to order available supplies that you might need to conduct the fairs. They could not anticipate the type or amount of supplies to order as they were not made aware of the types of tests planned. The one in charge of getting the list of needed supplies to us failed to do so and in 1 or 2 instances

we did not know what was needed until the day that particular fair began. This did create a problem for us as we do not stock these supplies in large amounts and I realize it was also handicapping to your group.

Another problem that we have noted is the lack of addresses and other identifiable information (husband's or children's parents names) on reports which handicaps us in locating people who need follow up (eg: those with a positive pap)

Third, DPT was given to children up thru age 10 years although the American Pediatric Association and the Tennessee Department of Public Health recommends not giving the vaccine to ones 7 years of age or over because of the dangers of severe reaction.

Please accept the above comments for guidance to you for any further such projects and not as "nit-picking."

We are receiving pap and x-ray reports in some of the counties and the nursing staff is keeping a list of these for you and are doing follow up on the ones needing it. Anderson County set up a "worm clinic" for ones needing rx for intestinal parasites but, sadly, not one came in!

In summary, my impressions were good in most instances but there were some breakdowns that did create some degree of a problem. If you would like, I will send you a summary of what has been reported to the Health Department and the outcome of our findings as soon as this information is compiled.

Sincerely,

Gertrude Malone
Public Health Nurse IV
Anderson County Public Health District

Clairfield Clinic

CLAIRFIELD, TENNESSEE 37715

PHONE: (615) 424-7555

September 21, 1970

Mr. William Dow
c/o Student Health Coalition
Box 49 St. 17
Vanderbilt University
Nashville, Tennessee

Dear Bill:

B efore answering the questionaire regarding the student Health Coalition's activities in the Clairfield area let me say that personally I was edified and impressed with the entire personell. Their sincere concern over the health status of our people led them to give of themselves unselfishly to each patient. They brought a freshness and eagerness of approach along with their desire to help which was appreciated by thei local people and the Clinic staff as well.

(1) The mobile unit was an effective means for testing and I've no doubt about the quality of the work done on the unit. I'm at a loss as to describe why it took so long for the large number of patients to be seen. Perhaps it was not designed to accomodate such large numbers of people at one time.

(2) Because this year's Health Fair was the third one for our community the objective was not to stimulate awarness of health care needs (eventhough attendance increased this year). The community in general was impressed by the concern shown by so many students and professionals and they responded by following reccomendations and inquiring after the results of their tests, quoting what "that young doctor told me" to friends and clinic staff, and asking after many of the individuals they'd met or shared their homes with.

(3) The follow-up of patients seen at the Health Fair could never have been accomplished without the students who lived in our community. The Law students were regarded by the community as very helpful and trustworthy.

The personal relationship developed between students who lived with or near our families have unlimited possibilities for growth on both sides. (I'm happiest about these results.)

Clairfield Clinic
CLAIRFIELD, TENNESSEE 37715
PHONE: (615) 424-7555

(4) I feel the quality of work was excellent. The notes taken during physical exams were too brief at times. Often major complaints by patients were noted. This was probably related to lack of experience in interviewing rather than inadeguate physical examinations.

When the records were reviewed as laboratory results came back, the student was severely handicapped - he had to diagnosis without having the patient in front of him and often without the help of faculty who had been available during the fair. Many patients were "over diagnosed". This posed a problem for us because when the patients were referred to local doctors it appeared that the M.D. dismissed the diagnosis lightly.

Our problems with referring patients without adequate incomes derives from the fact that Medicare and Medicaid patients cannot see some specialts - Opthomologists, dentists, ENT men.

(5) I'm not sure about long term affects - aside from the friendships made. I would'nt suggest any changes in the program as I feel just about every aspect of planning ect. was carried out.

(6) Our community will probably need only parts of the program next summer. Accessability to professional help is increasing. The gaps need to be assesed and planned for eg -.

The van with lab tests will no doubt be needed, screening for cervical cancer, specialty clinics, training sessions for local people who'll be eligible for jobs when CHP finally "arrives."

Thanks to everyone.

Sincerely,

Sr. Martha

Sister Martha Stucker, R.N.
for the Clairfield Clinic

EAST TENNESSEE CHILDREN'S HOSPITAL
2018 CLINCH AVENUE
KNOXVILLE, TENNESSEE 37916

November 12, 1970

Willlam W. Dow
Department of Pediatrics
Vanderbilt Hospital
School of Medicine
Nashville, Tennessee

Dear Bill:

I want to offer a belated congratulation to you on your Health Fair Projects this past summer. I was very much impressed that many of my criticisms from the previous summer had been corrected and was most impressed with the job which was done. This time, both the satelite and central clinics at Habersham impressed me as being much better organized. The members of the community were much more enthusiastic about what was being done and the physical facilities for actually doing the examinations were much better. Even in the make-shift clinic on the Kentucky border, the use of sheets to form individual examining rooms and the availability of gowns added a great deal in the examination.

There are a few suggestions that I could add to the job which you did last summer. I would suggest that an attempt be made to take patients aside to ask them the detailed past history. As it was, the first point of contact with the patient was to register them and take their history. Frequently a patient would be telling a number of details about his previous illnesses and symptoms to an audience who, no matter how little they wanted, could hardly help but hear every gory detail. The second suggestion that I would make is the people who precede the Health Fair could set up some way of feeding the patients into the examination stations by semi-appointment type schedule. For example, asking members of the community to sign up for the morning before 10:00 or the afternoon after 2:00. It might result in a better distribution of patients for examinations. It would also be an advantage to the patients who come, in that they might expect not to spend the entire day in line awaiting their physical examination.

Again on this occasion, I was not exposed to the follow-up procedures

for these patients. I was impressed with the few things which I saw turned up on your routine history and physical screening which had been overlooked by their own personal physicians, due to the speed with which they are forced to see their patients. Based on the fact that several of these communities are in the process of setting up their own clinics, I would assume that the follow-up was extremely good.

Again, thank you very much.

Sincerely yours,

Bill
William M. Hicks, M.D.
Medical Director

WMH:mc

THE DAVIDSON CLINIC

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LAKE WORTH, FLORIDA 33460
TELEPHONE: 585-9331

INTERNAL MEDICINE
SIDNEY DAVIDSON, M.D., F.A.C.P.
E. E. FUNDERBURK, M.D.
J. CLARK FORD, M.D.
HENRY FULLER, JR., M.D.
KEVIN J. McCARTHY, M.D.

DERMATOLOGY
S. J. FANBURG, M.D.

August 27, 1970

Mr. Bill Dow
Vanderbilt University
Medical School
Nashville, Tennessee

Dear Bill:

You asked me to write you a note about what I thought of the program and any suggestions that I have, so here it is. First of all, I would like to thank you for allowing me to work with you. I had a great time and it was a wonderful experience for me to work with such a group of dedicated people.

Now, let's get down to business. First of all, you have done a magnificent job. I must congratulate you on how well you did it. But, in any evaluation, we must think about what your goals were and how well you did or will meet them.

I think we can divide your goals into two types: immediate and long-term. Let's look at your immediate goals to begin with. The first and most ostensible one, was a relatively thorough medical screening of a large number of people who because of geographic location, lack of money or both, have been and are deprived of adequate medical care. This medical screeining, I think you accomplished magnificently. It is my understanding that you screened 800 to 1000 people a week for 8 weeks. I think the work you did was fairly thorough. The laboratory work, x-ray, EKG, physical examination, pap smears, etc., all were probably much more thorough than most of these people had ever had, and the organization of setting this up so this could be done was quite a feat, I think you did it well. The second immediate goal, whether knowingly or not, was to get a large number of dedicated young people interested in the problem of these medically deprived communities. This, I think you also accomplished. Certainly, the group at the end of 8 or 10 weeks of hard work were just as enthusiastic about what they were doing as they probably were at the beginning. Another, immediate goal, was undoubtedly a teaching one. Certainly the examination of a large number of people by your medical students, graduate nurses and nursing students afforded an excellent opportunity for them to become much more familiar with the every day medical problems of history-taking and physical examination. This was a very

effective teaching device but it was somewhat diminished by the oft time necessity of seeing too many people during too short a time span. This, as those of us in practice have noted, usually leads to inaccurate observations and poor medical habits. These badly acquired habits will probably be wrung out of you when you get back to the academic atmosphere of the medical school, I hope it will since this is quite important. Most errors in medicine are due to sins of omission rather than commission. Most sins of omission are done because of fatigue and pressure and slumping of medical habits. I expect, however, that all of you know about this and will conduct all of your medical affairs in the future in a more thorough manner than you were able to do while rushing too many people in too short of time.

I haven't discussed the nursing graduates and under-graduates since, in a way, they are a special case. Your utilization of them to do complete physicals, to work on a par with physicians, medical students on a routine medical assignment cannot be too highly commended. There is no question in my mind that the well-trained nurse can do any of the tasks that are now primarily in a physician's province. I am certain that they can do them as well as many physicians, if not better. The able nurse-practitioner, trained in physical examination can care of minor illnesses and minor surgery can help decide the great problem we have of the insufficient distribution of inadequate medical care. Your program is not alone in using nurses as you have, but there hasn't been enough of this and I hope that in your future efforts of this type you can continue along these lines using nurses and nursing students.

I have digressed some to go off on a tangent that I am personally quite interested in. Now, let's get back to your program. I am sure that you met your immediate goals, either as well or even better than you expected. However, what about the long-term affects of your program.

Now, for some of your long-term goals. I take it that you were trying to bring about in some way or other some fundamental improvement in the medical care of those communities that you went to and some of their surrounding communities. This, you thought you might do by interesting the local people in the health problems and instigating them to form health councils which would actively pursue the matter from a local level. It is my understanding that several have informed you and are actually going ahead with local problems. How effective these medical efforts will be, we of course do not know. But, unhappily and frankly, I am not overly enthusiastic about the staying power of such programs. I don't think they will be able to make it without a great deal of outside help, in the form of money, medical help, either from the state of from the large medical institutions of the state. In Florida, we have many communities that do not have adequate physician coverage and they find it very difficult in getting physicians. In many places, money is not the problem. Some of

these communities have an adequate supply of what it takes. However, physicians are not interested in living and practicing in these communities. As long as there is a scarcity of physicians and as long as physicians can live and practice almost anywhere they wish, they unhappily will not be dedicated enough except for a sparse few to go into areas such as you have there. I hope I am wrong, and I hope that you will be able to come back and tell me so.

As for the mechanics of your operation, don't try to do so much next time. I know one of your problems has been money. You have been quite successful in getting money to run your program, but I wonder if you have not been overlooking a source of funds which may help carry on your programs with a little less trauma on pocket books. I noticed that there were a fair number of people who were seen who were over 65. I am certain that these people all had A & B medicare and if they did have, although medicare does not pay for routine check ups, I wonder if some of your people at the university could not figure out a way in which you could be the recipient of some medicare benefits for checking these people out. I wonder, too if many of these people are not eligible for Medicaid and whether some of the Medicaid funds could be utilized for your program. I know this is a somewhat touchy subject, since you as individuals, not being physicians registered in the state are not allowed to accept any monies for "practicing" and that all the monies would have to be channeled through whatever physician is with you, I am also aware of the fact that Medicare frowns on the payment of funds to a physician who has not actually done the work. Be as it may, it may be that Medicare or Medicaid funds could be used in your program.

It may be that you have all ready thought of this and have been down this road. Your "legal eagles" probably thought about this long before I did and checked into it and found that it wouldn't work. If you haven't thought about it, see what you can do.

As for equipment, I certainly think that you can get some equipment from the surgical supply houses. I am certain that you could get an old EKG machine, if not more than one from some of the people who sell them. They very often take old machines in as trades and are unable to get rid of them. They certainly can give them to you and take it as a charitable write-off and it would cost them nothing. You might also go to some of your physicians, especially the large groups and see if they don't have equipment that they could give to you which they might be able to take off their income tax in such a way that it would cost them nothing.

That is about all the thoughts that I have at this time. If I have any other ideas, I will drop them to you in a note or drop Rick a note. I just talked to Rick and he says that you are still up in the Mountains, but I am sure that by the time this letter gets to the medical school, you will be back.

I must thank you for allowing me to work with your group, it was quite an experience and I thoroughly enjoyed every moment of it, including the fried chicken, meat loaf, green beans, the wonderful pies and the wonderful tomatoes all of which seemed to be typical of what you people have been eating for the past two months. I hope to hear from you soon, either directly or indirectly through Rick.

Sincerely,

Sidney Davidson, M.D.

SD/njb

cc: Mr. Todd Wright, Palm Beach Post Times
Mr. Rick Davidson

VANDERBILT UNIVERSITY
NASHVILLE, TENNESSEE 37203

322-7311
TELEPHONE ~~334-5111~~ AREA 615

Department of Chemistry
Direct phone 322-2861

August 12, 1970

Mr. William Dow
c/o Dr. Amos Christie
Vanderbilt Medical School
C-2311

Dear Bill:

This is in response to your request last night for suggestions as to how Vanderbilt could play a more significant role in helping to find solutions to some of the more pressing problems in the Jellico-Tazewell area of Tennessee north of Oak Ridge.

It seems to me that certain limitations are placed upon us by virtue of the fact that we are primarily an educational and research institution, and that our resources are finite. Thus, whatever we decide to recommend should contribute to the educational and/or research function of the University, in addition to assisting this area to deal with its very formidable problems. Failure to operate within this limitation would almost certainly guarantee a serious split within the faculty and administration over whether or not the proposals should be implemented, and might very well result in the proposals being rejected outright. A second point is that any proposal made should be formulated in such a way that carrying it out would result in the generation of minimum friction and divisiveness within the community, and between the community and the rest of the country. The country is already racked with division and turmoil, and it would be indefensible to add to this without excellent cause. Thirdly, any programs carried out should be handled in such a way that the people in the area are not made to feel that they are regarded as curiosities, specimens, or objects of our charity. This will require some care both in the selection and planning of projects and in the selection and briefing of participating personnel. I am sure that other limitations will come to mind as I have time to think this

thing over in more detail, but these are probably the major ones.

It seems to me that there are a number of quite useful projects which could be carried out which lie within these boundaries. I shall list a few.

1. Obviously the health program has been an outstanding success. It has been an excellent example of cooperation between an institution and the citizens of the area being served; my impression during the week I spent in Clairfield was that both the Vanderbilt people and the volunteers from the community regarded the project as "our" program, with the "our" including both groups. This is excellent. The quantity of medical services delivered was enormous, and the manner in which they were delivered was obviously acceptable to the "customers". Active participation by members of the community prevented the operation from being a "charity", and the behavior of the Vanderbilt participants was such as to create a feeling of friendly respect, rather than resentment of outsiders. <u>This program should by all means be continued</u>, and I would not recommend major modification in the way it is being handled with relation to the community.

2. The well and spring testing program should be continued, and a study should be carried out clearly establishing the relationship of water-borne diseases and polluted water in this area; the state government should then have this study called forcefully and publicly to its attention. In addition, the Environmental and Water Resources Engineering Department should be asked to explore the possibility of a project on the engineering of acceptable water supplies for this area. This, given the distribution of the people in the area and the very limited funds available, is a rather tough job; we have one of the best sanitary engineering departments in the country, however, and if the job can be done, they are the people who can do it.

3. The medical school and the law school should collaborate on a study of the black lung law to determine if it is accomplishing the objectives the public intended for it to accomplish, or if in fact it is a farcical tangle of red tape and frustration to the victims of black lung who seek aid through its

provisions. The evaluation of the law should be given to the Bureau of Mines, the appropriate congressmen, the President, the United Mine Workers, and to all newspapers and radio and television stations in the coal mining areas.

4. The law school, the geology department, the engineering school, and the general biology department should be invited to carry out a study of strip mining laws, the effects of strip mining in the area, and the effectiveness of methods for reclaiming strip-mined land. Obviously Tennessee's present strip mining law is totally ineffective in bringing about the reclamation of land which has been stripped. Stripping without reclamation inflicts massive and permanent damage to the land, making it worthless for use as anything other than a city dump, cutting off access to large parcels of land by both people and animals, creating soil erosion problems, silting in reservoirs, and increasing acid mine drainage.

5. The major problem in the efficient delivery of medical care, education, water, sewage treatment, and other services in this area is the dispersion of the people throughout the tiny hamlets and hollows. If they could be concentrated in towns of modest size, the cost of delivering these services would be greatly reduced, and there would be an administrative structure to deal with these problems at a local level. I therefore propose that sociologists, psychologists, and perhaps a geographer or two explore the reasons why these people are so strongly opposed to modification of their way of life, and that this task group see if there is any likelihood of a plan being developed for bringing these people into towns which would meet their more serious objections and fears and which would not be psychologically and sociologically destructive to them. If it appears that such is possible, I propose that some work be done in "micro-urban" planning for such resettlement, and that this planning be carried out with the active participation of the members of the local communities.

6. I propose that the school of management and/or the economics department be encouraged to explore with the chap who lives in Clairfield (whose name I forget--I think that he's with the OEO or the Appalachian Regional Commis-

sion) the possibilities of their participating in the determination of potential business and industrial opportunities in this area. The area needs jobs desperately; this is the fundamental problem underlying all others.

That about exhausts the ideas I've come up with; if I think of anything else, I'll get in touch with you.

Don't let Charles Schiff get away without winding up that report on the wells and springs for you. Even if it means that he gets a few less wells tested this summer, the long-range effects of that report upon the state government are likely to be sufficiently great to make completion of the report extremely worthwhile. One of John J. Hooker's lieutenants (Alfred Knight) has expressed considerable interest in this project, and I think that a good report issued in the near future on this problem might bring about major improvements in the situation.

Do give my best wishes to all of the crew.

Sincerely yours,

Dave

David J. Wilson
Professor of Chemistry

DJW/bsk

VANDERBILT UNIVERSITY

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329

July 27, 1970

Mr. Bill Dow

Dear Bill:

As I indicated to you, I am writing about my impression of the operation which we participated in in White Oak. As you know, I was very enthusiastic about the project, but I must say I have come back with a number of second thoughts. I will try to put down my impressions as objectively as I can.

First, I think that the whole project must be judged in its merits on three entirely different levels. First, as a teching operation; second, as an operation in the delivery of health care; and third, as a political operation. I believe that these three aspects of the project must be clearly differentiated in everyone's mind before any kind of overall evaluation is made.

First, as a teaching project: It leaves a great deal to be desired. It is obvious that you are involved with quantity and not quality. It is very questionable in my mind whether the poor habits I saw practiced in White Oak will be able to be overcome by students in their first and second year. I believe they indulged in sloppy thinking and sloppy performance for a number of reasons. Perhaps, the most important is inexperience. One can defend that in that this was an opportunity for them to gain experience in learning how to do physical examinations on large numbers of patients, but the circumstances under which they were done, and the lack of quality control in the face of enormous numbers of patients, make this a questionable learning experience in my opinion.

One of the basic problems is your inability to have either on line data or for individuals who have examined a patient and obtained some information to have any kind of follow-up to know whether or not he was right or wrong in his pathological diagnosis. This must be terribly frustrating to the student. It certainly was frustrating to the consultant. Another thing which was disturbing about this as a teaching operation was the extremely poor circumstances for the physical examinations. After the first few hours, the first day, everything was dirty. I found it hard to believe that one can impress on a patient the necessity for good personal hygiene,

when one does not practice it himself. I found many of the student examiners to be dirty, and with poor personal hygiene, some of which might be explainable on the basis of their living in homes where running water was not available. However, I have lived in similar circumstances for fairly long stretches of time, and it is possible to maintain some semblence of cleanliness, even in the most primitive circumstances. No one washed his hands and this included, even Pete Moss. To examine patient after patient, particularly with pelvics and rectals, even though gloves were worn, without ever washing ones hands, must be a degrading experience for both physician and patient; and for the student physician to have dirty clothes, body odor and halitosis is inexcuseable.

Another problem with the teaching, which is certainly not your fault, but perhaps ours in planning, is that the faculty which is going to be available to you and has been available to you, is not necessarily the best choice for the population you are seeing. This adds to the student's inability to receive good teaching under these circumstances. It was obvious to me that what you needed was a number of excellent internists and one good pediatrician, with perhaps, someone with a knowledge of gynecology on occassion. The poor habits which the students exhibited were exaggerated by this pressure of time, since when patients got stacked up, everyone felt the necessity to keep moving and get them out as fast as possible, regardless of the quality of the procedure.

Another considerable deficit as a teaching process to me was the check history done by someone other than the physician. This check history was rarely elaborated on by the student and certainly in no detail, and I found that their presentations were poorly documented and poorly organized.

As a demonstration in the delivery of health care: To a population which is not receiving health care, this has to be judged in an entirely different context. I don't think that anybody can argue with you that some medical care is better than none. However, I believe that it could have been considerably more polished. I thought the circumstances under which many of the patients were examined was very dehumanizing. To have an elderly woman lying on a school desk for a pelvic, done by a dirty medical student who was unskilled, draped only in a gown which had been worn by many other patients and lying on a piece of paper which had been there for several days, is really not what I would want to subject people to with any pride left.

Again, efficient care is hampered by the fact that the consultants available to you are not necessarily the most appropriate and the lack of on line data makes the ability to work up a patient adequately very frustrating. For instance, it was obvious that with urinary tract infections, intravenous pyelograms ought to have been done, and yet, we had no ability to do these. We could not dictate the ultimate care which these patients would receive, even if it were to be available. This is frustrating and unsatisfactory.

Children could usually be handled with some ease because of their acute problems, but those poor adults with multi-system disease really could not

be adequately worked up in the pressures of time, and the circumstances under which they were seen. Your follow-up may show you how successful you are in getting these people to adequate health care, but this will take not only identifying the patients on follow-up, but information on whether or not health care was actually ever received.

The very good things about the patients care delivery were things that had to do with preventive medicine. For instance, the immunizations, the screening of urine, chest x-rays, and such. This is useful information and successful public health. The stop-gap therapy which I saw being practiced was poor. It proved to be frustrating to both patient and student. I do not think that this kind of operation should be considered one of delivery of definitive therapy in any sense. It seems to me that if you had picked four places instead of eight, and planned to spend two weeks at each place instead of one, that the pressures of time and space would have been much less acute and that you could have done a much more careful and satisfactory job identifying the problems in a given area.

As a political operation: I think much of what was being done will be useful, especially in organizing communities to think about and to be more responsible for their own health care. I thought the organization of health councils and the participation of the local people in their own health fair was extremely valuable for the future development of some permanent system of health care in those areas. This kind of operation can be extremely useful in pointing up the deficiencies in the system, such as the inadequacies of Medicade and Medicare in providing the elderly or the indigent when there is no physician or hospital which can take care of them in their locale. It can also point up the problems to the local physicians and to the health agencies such as the Public Health Officer and the Public Health Nurses. However, antagonizing these people is not going to solve the problems or make them more responsible to these people's needs. As a matter of fact, it may do more harm than good, and I aaw a good bit of animosity and antagonism openly expressed. The types of problems presented by having the County Seat where health agencies might be available, so distant and so expensive a trip for population that it would serve, is vividly exemplified by Tazwell.

As you know, better than I, health is only one aspect of these people's lives which needs attention and improving their health will only be useful to them as long as one improves the other states of their existance. Economic stability, reclamation of the land and control of the mine operations to prevent recurrences of what has happened in this area, must all be linked with the provision of health care or you are really wasting your time.

There were a number of strengths in the operation. It was perfectly apparent that a lot of preparation, organization and footwork had gone into the operation before we arrived. The participation by the community people themselves was extremely impressive, and I believe your own part in organization was tremendously important. The greatest strength, as far as medical impact is concerned, is the demonstration that nurses could be used to do basic screening when they had adequate preparation and back up as far as supervision was concerned. I found your nurses the most enthusiastic and diligent of the examiners, and I believe that a Nurse Practitioner Program could be set up on a limited scale in the Nursing School at Vanderbilt and used as a demonstration that this kind of person can not only be taught to deliver preventive medicine and do health screening, but perhaps to deliver some prime care, much as Sister Martha does in that area. As I have indicated to you in the past, I believe that there are two pre-requisites for using non-medical personnel as prime care deliverers. One is their ability to communicate at all times with consultation. This might readily be provided through such things as the regional medical programs attempts to have telephone consultation services set up much as they have at the University of Alabama. A second and perhaps more important pre-requisite is the ability to transfer patients out of their local scene, once the health problem exceeds its ability of the local situation to meet it. This means the ability to hospitalize elsewhere and this means some method of assured payment. It also means easy transportation to remote areas. Both of these aspects need to be thought about very seriously before a nurse practitioner, however skilled, should be placed in the position of responsibility in a rural area.

The most impressive example that one could find would be Sister Martha, who I felt was a tremendous strength for the area and an extraordinarily strong woman. However, she must feel very isolated at times, as illustrated in her inability to get patients to definitive care.

There were a number of weaknesses to the operation which I do not believe you can overlook. One which I classify as a weakness, but perhaps you classify as a strength, was the overt contempt which you and some of the others expressed for your ties with the University and for the Medical School Faculty. This was also reflected in your attitude toward any other representative of any establishment such as the Public Health Nurses, the LMD's, etc. Whether you like it or not, the University has ties to you and you to it, and you could not have launched this operation without a considerable amount of backing, particularly from the Medical School and its Faculty. You will also have great difficulty in projecting this into any future curriculum or with any other medical school faculty participation if this kind of reaction is diaplayed. No matter how inadequate you feel some of the faculty might be as your consultants, you requested their presence there and as I've indicated before, one of the problems is that not all of the faculty who are interested enough in this operation to spend several days and some effort in trying to both inform themselves and participate with you in the operation, are the very best people who could have helped you with your own problems, but they are there on your request, and I

believe should be treated with some consideration. I don't believe by antagonizing the local health establishment that you improve matters and you may get yourself into extremely deep trouble which will jeopardize the whole future of the operation. My biggest concern for this operation from the first time I knew anything about it was that it demonstrated an anti-intellectural approach to medicine. I'm afraid that there was considerable evidence that this was true in the approach toward medicine that I saw in White Oak.

Another problem which you perhaps recognize more than I, is that many of your students have now begun to be bored by the operation. I saw a good bit of "goofing off" and there was certainly evidence that everybody wasn't working equally hard. I think you also must realize the problems of Stan Von Hoff working in Clairfield without medical coverage. I think it would be very unfortunate if Stan were to get into difficulties because of that.

I don't know how much of this will be useful to you. Perhaps, you won't accept any of it. If you're interested, we can talk about it further after you come home. I hope the rest of the summer's operation goes smoothly, and if there's anything I can do to help out, let me know.

With best wishes.

Sincerely yours,

Mildred Stahlman

Mildred Stahlman, M. D.
Professor of Pediatrics

MS:hj

VANDERBILT UNIVERSITY

NASHVILLE, TENNESSEE 37203

TELEPHONE 254-5411 AREA 615

Department of Preventive Medicine and Public Health • School of Medicine

October 12, 1970

Miss Kathleen Brewer
Student Health Coalition
Room C-2311 Medical Center

Dear Miss Brewer:

I will attempt to answer your questions and be as brief as possible.

How would you evaluate the quality of the Health Fair? I thought the quality of the physical examinations by the students were quite good. However, there were times when they weren't adequately supervised and this I think should be avoided at all costs. When I visited, the Fair was being held in Habersham. I was asked to do routine physical examinations and, being new to the program, consented to do so. However, in retrospect, it might have been much better if I had served exclusively as a teacher and supervisor rather than doing physical examinations. At any rate, it was my observation that almost all the women I examined in Habersham had their own private physicans. Many of them had been examined within the past two or three months and they had all had pap smears quite regularly and almost all of them were within the past year. I realize this may have been an error in selection, that is, getting a town so close to medical care that there weren't any serious problems. However, in the future, I think it would be good to avoid towns like Habersham where they seem to have reasonably adequate medical care.

As to a long-term relationship between the project and the university, I think this is frought with all kinds of very serious problems. In a way, I liken it to the Viet Nam War. If I were the President of the United States and really wanted to do something stupid, I would become involved in a civil war 10,000 miles from home. In a way the area around Clearfield is similar, it is a long way from Nashville. The problems are very large and probably more than we as a university or medical school can take on and successfully solve. It is my belief that these problems can only be solved by the people themselves in the community. Of course they are certainly going to need outside help, but I don't believe Vanderbilt is in the position to offer them the kind of help they need.

Another question that concerns me about it is our goal, is it that of a learning experience for students or actually to take over and furnish medical care for the community? These are two entirely different subjects as I see it and I am very much in favor of the learning experience for the students, but I am not in favor of Vanderbilt taking on the medical care of these people which in reality are relatively small in number and the amount of effort that would have to go into such a project might be overwhelming. It certainly would be with our present faculty size.

I think it is fine, and I personally would be flattered if students were to call on me for assistance, especially to help them plan and supervise summer activities.

What effect, if any, do you think a student project of this kind might have upon improving medical care delivery? Actually, I don't think this will have any effect at all on improving medical care delivery. It was a health fair, a case-finding effort, and I don't believe the students themselves thought they were going to accomplish very much in delivering medical care. If this sort of experience is going to continue, I believe at least the medical part of it should be medical school based. It should have a home where the students could plan with the faculty and there could be a very close student-faculty relationship in all aspects of the program. The only way I could see that Vanderbilt could staff a rural hospital or clinic in East Tennessee would be for us to obtain the necessary medical personnel, which we do not have at the present time. I suppose it is possible for house staff to be assigned to rotate through the hospital there with supervision, but again, this takes a lot of planning and I am not sure that you would find many house staff who would be willing to do this. There would undoubtedly be some, but they would have to be sought out and then of course there would have to be supervisory faculty at the senior level to guide them as well as students who might be there, both nurses and medical students.

Concerning the nurse practitioner program, I think this is a very worthwhile project. I think it should be tried to find out just how useful or practical a nurse practitioner can be. She will have to learn to live with the medical profession and vice-versa, but I don't see any way of accomplishing this other than actually going ahead and training some and learning through experience how their talents can best be put to use in relieving the physician of some of his load.

If I were asked to help another time, would I do it? Yes.

I hope these notes will be of help to you and if I can be of any help, please let me know.

Sincerely yours,

Robert W. Quinn, M.D.
Professor and Chairman

Nashville, Tennessee 37203
telephone: area 615/254-5411

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August 7, 1970 VANDERBILT UNIVERSITY

Mr. Bill Dow
General Delivery
Deer Lodge
Tennessee

Dear Bill:

I just wanted to write you a note and tell you how much I appreciate the interest that you students have in caring for the ill. I am terribly impressed with what you have been able to put together and wish you well in the future. You may be interested to know that I have heard many favorable comments from the faculty members who have been there including Paul Slaton, John Chapman, and others. I hope that your idea for the Wellicoe Hospital goes well and that the private practitioners do not beat us to it.

The future survival of our country depends, in my opinion, on the well-motivated activities of students such as you and those working with you. I am sure that many of your aspirations are not too well organized at the present time, but that makes no difference. With polish, all of them that are true to their convictions will be successful.

I think that the faculty is capable of turning its head to new directions if you will give it a chance. I urge you strongly to continue in your own way to generate enthusiasm among the students and it will catch on in the faculty. This will be a great thing for our school if properly organized and directed.

Let me know if I can be of any future assistance.

Sincerely yours,

Anderson Spickard, M.D.

AS:lcw

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337

October 27, 1970

To: Rod Lorenz

From: Harold H. Sandstead HHS

Subject: Comments regarding Student Progress in Appalachia

I assisted at Briceville. I was impressed with the students organization and the smoothness of the operation. It was clear that they were overworked by the large number of patients. They came to me and requested consultations on problems and displayed appropriate concern about the diseases and treatments of patients.

I believe the program has educational value not to be found in the well-structured environment of the university hospital. The students were confronted with the hard realities of the current state of medical care within Tennessee rural areas. They also had the unusual opportunity of getting to know the people they are dealing with. From this experience, they probably have a greater appreciation for the problems of this particular group, than they would gain in the setting of the hospital clinic. I hope their experience will color their attitudes regarding medical care and the obligations of the health care delivery system for the rest of their lives.

Concerning specific questions asked by Kathleen Brewer: 1) The health fair operated well, considering the setting. Physical examinations were not first class, however, they were probably adequate to pick-up gross pathology. The students asked for help when problems arose. 2) I viewed myself as a helper, as available to do what I was asked to do. I believe the project will best function over the long haul if the attitude expressed above can be preserved. Guidance by faculty should be given with tact and not in any ham handed manner. Students should feel free to call on faculty. The mission of the faculty is to teach. 3) Projects of this sort may stimulate existing agencies to deliver health care projects of this type to bring problems to light. Vanderbilt's role should be one of a teacher. If running clinics will fit into the educational structure, Vanderbilt should become involved in running them. The major mission of the university is not service, but rather education. Nurse practitioners are long over due. 4) Yes, I would be pleased to help.

HHS/mgh

EVALUATION OF STUDENT HEALTH COALITION
F. T. Billings

I spent a very interesting exciting and informative day with William Dow at Deer Lodge and Clairfield. Naturally, my observations are superficial but I think I can point out basic problems and assets.

In commenting specifically on the questions posed by the Student Health Coalition, the brevity of my period of observation must be kept in mind but this should be bolstered by my personal feelings of overall approval of the sincerity and imagination and industry displayed by the students.

1. The Health Fair I saw at Deer Lodge was obviously a community project organized by the people with the help of the students. In this it was unique and valuable. It seemed well organized in a bustling enthusiastic disorganized fashion. The areas of most strength were the interest and participation of the people and the use of technologic survey methods. The physical examination could not be optimum because of a) lack of experience of most of the examiners b) the difficult conditions under which examinations were performed c) the lack of specialized senior supervision.

2. I could not be considered a responsible faculty member of the team. I felt more in the roll of an observer during my brief visit. A faculty member should be responsible for the quality of overall patient screening and examining particularly in his field of specialty. He should be expected to make suggestions and have them carried out regarding patient management. Continued participation of faculty on an inadequate catch-as-catch can basis is unsatisfactory. Better organization probably on a higher administrative level seems necessary. If personnel and financial support can be obtained, it would seem desirable for the University to increase involvement.

3. I think a student project can improve the health care situation but only if there can be proper professional follow-up. Vanderbilt's roll in community health must be strengthened. Whether it should be in East Tennessee or more locally situated where transportation and communication logistics and problems of isolation are less intense are important questions which should be considered carefully. I think a nurse practitioner program is absolutely necessary.

4. I would help if asked. It is an important and interesting project.

F. T. Billings

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Department of Medicine • School of Medicine

339

September 3, 1970

Miss Kathleen Brewer
Room C-2311

Dear Miss Brewer:

I should like to furnish the following answers to your questionaire:

1. In general, the Health Fair was effective in the community where I worked. The quality of the physical examination per se was fair. The major benefits came from the screening tests that were performed and the advice given to the participants. I was troubled by some tendency of the medical students to treat chronic diseases with whatever drugs were available. In the community where I worked,a good relationship had not been established with the single practicing physician. The Fair could utilize more clerical and other ancillary personnel to complete forms for the examiners and do jobs of that type. The examiners spent a great deal of time at these tasks.

2. It is my view that the ideal role of faculty member is to advise the medical students concerning the significance of abnormal findings and to provide other advice based on his experience. A long-term relationship between the project and the University is entirely feasible. The resources of the University could be utilized to correct many of the deficiencies that were present. I feel that it is entirely appropriate for the students to call on the faculty for assistance.

3. I feel that the student project as it now exists has very little impact on the health status of the East Tennessee population. The project does have and important function in demonstrating the problems associated with the delivery of health care in remote areas.

This aspect of medicine has been grossly neglected at Vanderbilt for many years. I would like to see Vanderbilt establish an institute with its primary function the delivery of health care. This would include research in methods of delivering health care as well as the actual service aspect of health care. I should think that communication links could be established with the physicians in remote areas and modern means of transportation utilized to bring the patients to treatment centers. The Tennessee Medical Society has apparently disapproved a system similiar to this which was proposed by the Regional Medical Program. In general, I am in favor of nurse practitioner programs and physician assistant programs and feel that they are the only practical way of solving the physician shortage.

4. I should be happy to help the Student Health Coalition again.

Sincerely yours,

Raphael F. Smith

Raphael F. Smith, M.D.
Assistant Professor of Medicine

RFS/tb

Alan L. Graber, M.D.
Department of Medicine
Vanderbilt

Answer to Faculty Evaluation

1. Quality of e xams was limited primarily because of students' lack of experience in this area. Some of the students had never even had a physical diagnosis course. Pelvic exams were particularly inept on the day I was present, being performed by a most inexperienced student from another school. As for the whole project, you did best in aspects of organization and enthusiasm, and the greatest problems were lack of experience. I would suggest special training sessions in routine physical diagnosis in preparation for future Health Fairs - and I would make sure that freshman students were better-instructed and supervised - incidentally, the nurse examinations in pediatrics were of very high quality.

2. A good question - most important, and hardest to answer. I came only as an observer, to try to obtain answers to this question. I think the ideal role of faculty members on a short-term basis should be consultative and for teaching - similar to that of a teaching attending physician's relationship to a resident on a ward service. The students' running of the show is most impressive - faculty should only intrude on that if they expect to devote a large share of time and follow-up to it. The students should use every device known to man to call on the faculty of both the Medical and Nursing Schools for assistance - including threats, kidnapping, guilt fellings, pleading for help, etc. Each faculty member will respond in his own way to the appropriate stimulus. A longtime relationship between this project and the institution is a "nice," ideal goal - but it totally depends on the personnel involved on a longterm basis. A relationship on paper only is not very meaningful; and informal relationship, however, may be very productive if active participation and interest on the part of the faculty can be maintained.

3. It is a good demonstration of what concerned individuals can do. Whether or not it improves health care delivery depends on the results of your follow-ups, with which I am not familiar. It would be nice for Vanderbilt to staff a rural or East Tennessee Hospital if it had the resources to do this in addition to playing a more definitive role in this community. For the present I think more emphasis should be spent on this community, however. Only if additional staff and resources remain after a massive effort to improve health care in Nashville--or, if certain individuals, such as yourselves, preferred to work in rural areas rather than closer to the hospital, should rural care be emphasized. The problems of

logistics are much easier if close at home.

The proposed nurse practitioner program should be very useful.

4. Yes - because this is a worthwhile project which demonstrates that improvements in health-related projects are possible when actively pursued by dedicated individuals like the Student Health Coalition.

Alan L. Graber, M.D.

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September 3, 1970

Mr. Bill Dow
Student Health Coalition
Room C-2311 Medical Center

Dear Bill:

In response to your request for an evaluation of the coalition's summer project, I have the following comments and suggestions. I believe that your summer program was extremely successful when viewed as a whole program and compared with your objectives as they were stated in your presentation to the Department of Medicine faculty. I think you unquestionably made an impact on the people in each of the communities which you visited and made health care a more important concern for them. In addition, it is apparent that you created the desirable concern and attention on the part of the political and economic establishment, making them more aware of the deficiencies of the present system. You also made an impact on the Vanderbilt Medical community and made them more aware of the needs of a community health program as an integral part of their function.

The health fair which I attended in Deer Lodge was well organized but because of the rain was poorly attended. I think, rather than being a disadvantage, it probably was somewhat of an advantage in that the quality of teaching was perhaps somewhat better than was reported by faculty from previous places. It was quite remarkable to see the tremendous job being done by the first and second year medical students and by the nurses. The worse problem which I noted was the poor quality, in fact, harmfulness of the history sheet. It was poorly structured and poorly filled out to the point that it was not only of no use but was a delay in taking a good history in order to check out extraneous points. I do not have the background at this moment to tell you what form might be better, but there must be a good form somewhere which would help or else there must be better ways of instructing the individuals filling out the history sheets. In checking some of the charts with information back it was quite apparent that the positive findings and the history had very little correlation. It perhaps would have been far better simply to have had a list of the patient's own complaints as he wanted to list them in order of importance. The area of best performance in my opinion was the performance of the nurses in examining the children. Perhaps even more important in a positive sense was the effect of the advance organization of the community which was done in preparation for the health fair. This was obviously a very effective effort.

The presence of faculty in the program seemed to be greeted in two different ways. The leadership of the program seemed to feel that faculty were a necessary evil in order to satisfy legal requirements. Because of the relaxed pace, the

workers seemed to call freely upon the faculty as consultants and I think derived a significant amount of teaching value from their experience. The leadership of the summer project could benefit from faculty consultation in their organizational efforts for any future program. Students should certainly feel free to call upon the faculty for assistance, and would probably get better cooperation by involving the faculty and administration in the planning stage as well as the stage of execution.

The student summer project is of itself unlikely to improve medical health care delivery. It might, however, stimulate Vanderbilt University into getting into research in the area of medical care delivery and thereby indirectly attain this goal. Vanderbilt should be involved in this, but in order to do so there must be an increase in the faculty with some people devoting their full attention to this effort. In addition, the University would have to make a decision as to whether its energy in health care would be spent in Appalachia, or in urban Nashville. There is just as great a need in urban Nashville as in Appalachia.

The function of nurses in a screening capacity seems an important step in the provision of medical care for under-developed regions. I believe this program should be pushed vigorously by Vanderbilt University.

If such a summer project is again organized, it would seem extremely important to gain the very most out of the vast amount of energy and money put into the program. In my opinion, this would require involving Dean Chapman in a prospectively developed evaluation of the educational worth of the program. It would also invovle a carefully planned evaluation of the social change wrought by the community organization and the health fair. This would probably require help from the Sociology and Psychology Departments of the University as well as your own staff.

If I were asked to serve again, I would if there were sufficient time and if the program were set up in such a way as to guarantee educational value for the students involved. I would be unwilling to act as the legal protection for a massive screening project which produced sloppy results. To avoid this would require a limit to the number of patients seen per day, and a longer time spent in each community.

I wish you well in your deliberations about the future of the student summer project.

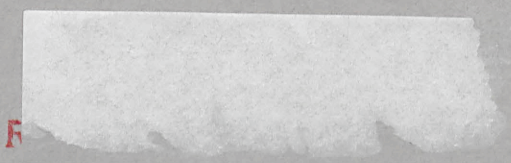
Respectfully,

James D. Snell, Jr.

James D. Snell, M.D.

JDS:jd

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DEC 2 4 '08	MAR 2 4 20	11/2/13	10/6/15
DEC 3 2 '08	MAR 2 9 2012	2/1/14	
DEC 2 3 '08	APR 0 3 2012	4/28/14	
JAN 0 9 '09	4/6/12	7/7/14	
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MAR 16 2006	SEP 11 2007	OCT 22	UG 13 2011
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Student Health Coalition

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DATE	ISSUED TO
MAR 1 '82	
MAR 1 '82	J. Owens 3-24 Light
	REC'D APR 1 3 1982
	Overdue Light 3-16-82
APR 2 7 '82	P. Feeto MD/BS
	ROOM 101 L+H
	REC'D JUN 30 1982
MAY 1 1 '82	Renewed uw
JUN 2 '82	RENEW
JUN 1 6 '82	Renewed uw
JUL 1 '82	RENEWED
	REC'D JUN 30 1982

DEMCO 32-207

DATE	ISSUED TO

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